Government of Saskatchewan

Annual Report 2001-2002

Saskatchewan Health

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Letters of Transmittal

To Her Honour
The Honourable Lynda Haverstock
Lieutenant-Governor of Saskatchewan

May It Please Your Honour:

I respectfully submit, for your consideration, the annual report for Saskatchewan Health for the fiscal year ending March 31, 2002.

This report continues to reflect a move toward greater accountability within government and Saskatchewan Health in particular as we strive to offer the best possible health care to all citizens of our province.

Respectfully submitted,

John T. Nilson, Q.C.
Minister of Health

To the Honourable John T. Nilson
Minister of Health

Minister:

On behalf of the staff of Saskatchewan Health, I am pleased to present to you the department's annual report for your consideration. In accordance with *The Department of Health Act*, *The Prescription Drugs Act*, *The Saskatchewan Medical Care Insurance Act*, and *The Vital Statistics Act*, this report covers the activities of the department for the fiscal year ending March 31, 2002.

I would like to commend Saskatchewan Health staff members for their continued dedication to ensure all citizens in the province receive the best possible health services.

Respectfully submitted,

Glenda Yeates
Deputy Minister

A Message from the Minister of Health

In the face of continued debate over the future direction of health care in Canada, Saskatchewan Health remains committed to providing a publicly funded, publicly administered health care system that ensures healthy people and healthy communities.

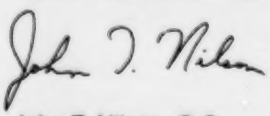
As we enter the 21st Century we recognize that change will be needed to sustain our current system. Saskatchewan was one of the first provinces to undertake an in-depth review of how our health services are delivered.

The recommendations of the Fyke Commission on Medicare were followed by careful study and consultation with Saskatchewan people. We heard clearly that our residents have an enduring belief in a health system where access to care is based on need, not ability to pay. But, they also recognize that our system needs to adapt and change in order to remain strong. To guide this change, we developed *The Action Plan for Saskatchewan Health Care*. This plan provides a long-term blueprint for our health care system to improve the way we deliver everyday health services, while ensuring the best value for every health dollar.

Development of the action plan was a major focus of the past year for Saskatchewan Health and its partners. This annual report will feature highlights of the plan and identify steps already taken toward implementation. It will also reflect the many other notable activities and achievements from 2001-02, as well as the ongoing challenges faced by the department.

One of those challenges is to improve how we report to the public about the performance of our health system. In this annual report, we are continuing to expand the use of "performance indicators." These indicators help us measure the health of our residents and the operation of our health system, and point to areas where we can improve delivery of services. In the coming years, we will continue to develop these indicators and others, to create readily recognized standards by which to measure our results.

In the past year, we have made great progress toward securing the future of health services in our province. I look forward to working closely with our partners in the health care community as we continue to implement the changes outlined in our health plan. Together, we will reach our goal of a stronger, more efficient health system that ensures accessible, quality health care within our financial means, well into the future.



John T. Nilson, Q.C.
Minister of Health

Who We Are

In Canada, both the federal and provincial governments play major roles in the provision of health care.

The federal government provides funding to support health, education and social services through the Canada Health and Social Transfer (CHST). Transfers to each province are based on population. To be eligible for this funding the Canada Health Act outlines a number of principles to which provinces must adhere in delivering insured hospital and physician services to their residents.

The federal government is also responsible for providing health services to certain members of the population (e.g. veterans, military personnel and First Nations) as well as for maintaining the safety for food, drugs and various health products, in Canada.

Provincial governments are responsible for other aspects of health care delivery. As a department within the Saskatchewan government, Saskatchewan Health sets policy and standards for health services and administers the province's health budget of more than $2 billion. The department is made up of a number of branches that focus on specific program areas such as the drug plan or physician fees. An organizational chart for the department is included on page 5.

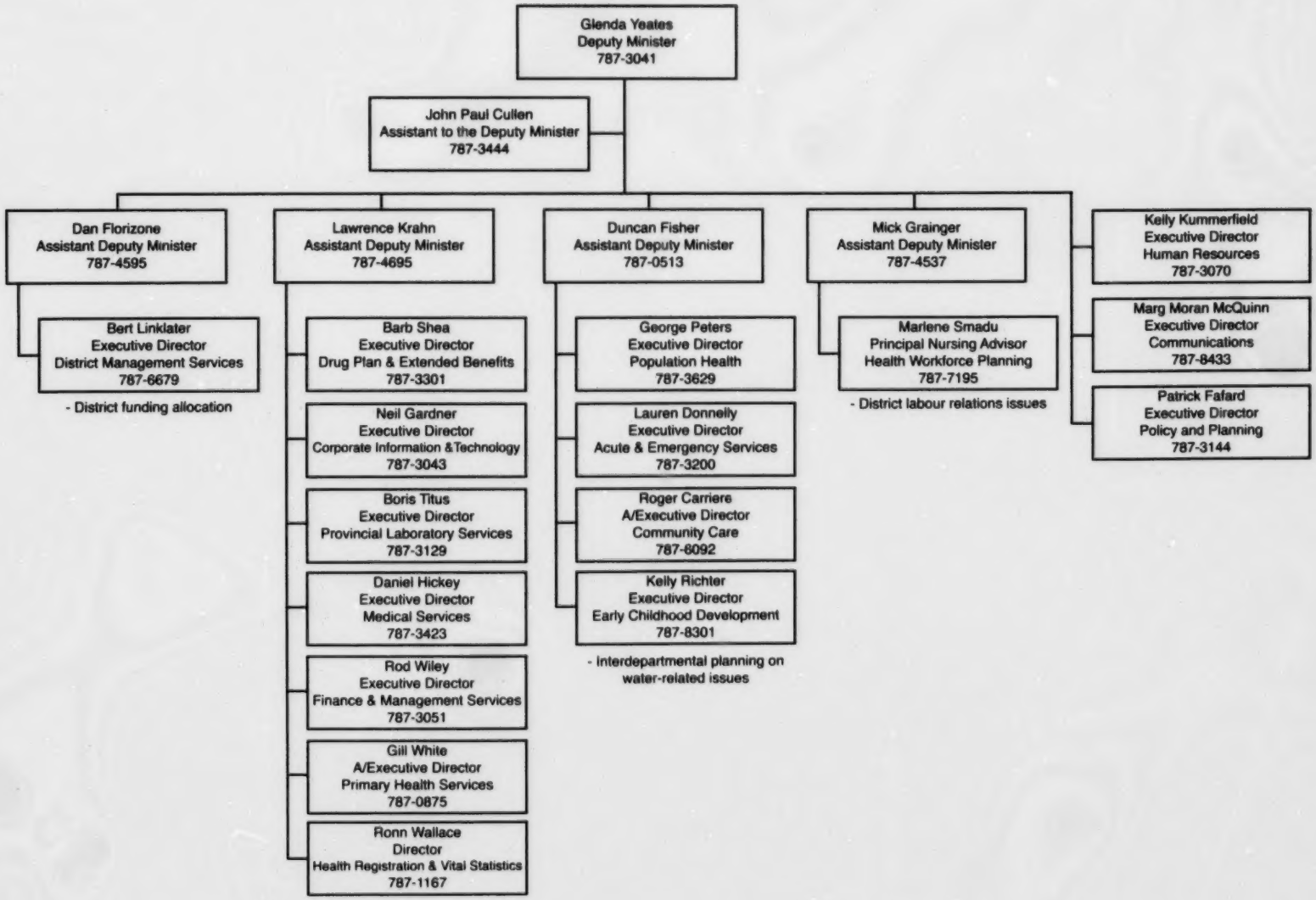
In 2001-02, Saskatchewan Health provided funding to 32 health districts (see health district map in Appendix III). This funding, which totalled close to $1.3 billion, is based on population and is adjusted for a number of factors such as age and gender and where people go for health care services.

District health boards are responsible for assessing local health needs, planning and delivering health services to meet those needs. For example, districts operate hospitals and health centres, and deliver a wide range of community-based services such as home care, mental health and addictions services, public health services and programs to help residents stay healthy.

Districts work closely with Saskatchewan Health to maintain overall standards, so residents can be assured of a consistent quality and level of service no matter where they live. On August 1, 2002, the 32 health districts were consolidated into 12 regional health authorities, which will assume responsibility for service delivery across the province.

The Minister of Health has the ultimate authority and responsibility for the health system overall. The Minister oversees the work of Saskatchewan Health and is accountable to the Legislature.

Saskatchewan Health
Minister of Health – The Honourable John T. Nilson, Q.C.



Organizational Chart as of March 31, 2002

The Year in Review 2001-02

Saskatchewan Health enjoyed many successes in the past year. Any review of the year 2001-02, however, must begin with *The Action Plan for Saskatchewan Health Care*. The release of this blueprint for the future of our province's health care system was a major accomplishment that will guide the department's efforts well into the next decade.

This year in review section is divided into six chapters. The first, entitled "Key Activities," includes highlights of the Action Plan as well as other noteworthy accomplishments from the year 2001-02. These include ground-breaking tobacco legislation, and initiatives to tackle the challenges of retaining and recruiting key health care professionals.

The four subsequent chapters are built along the broad themes outlined in the Health Plan, and highlight the many other achievements of the department during 2001-02.

Promoting Good Health looks at work done by Saskatchewan Health to promote healthy lifestyles through, for example, immunization services, diabetes prevention and education programs, and other public health services.

Improving Quality and Accessibility looks at some of the innovative ways Saskatchewan Health is seeking to meet the challenges of delivering key services such as primary health care and surgical care.

The health care system in this province employs tens of thousands of people. *A Strong Workforce* examines how Saskatchewan Health is seeking to ensure a stable supply of key health professionals.

The chapter *Efficiency and Accountability* examines the steps the department is taking to address long-term sustainability of the health care system. This chapter paints a picture of health spending, and provides some examples of the costs of typical health services.

Finally, the chapter *Health Spending in Saskatchewan* examines the measures taken to ensure financial accountability to the people of this province.

Throughout this review section, we have attempted to provide whatever information is currently available on health system performance and overall health status. Providing facts on these outcomes is important, as we seek to become more accountable to the people of Saskatchewan.

There are many limitations to these measures, however. Established, reliable measures are still being developed. There is often disagreement on how to interpret results. In addition, many of the factors that are vital in determining good health, such as poverty, housing and education, fall outside the direct influence of the health system.

Wherever possible, we will use acknowledged traditional measures such as infant mortality and life expectancy, which have become standard, not just in Saskatchewan, but around the world.

One final note: because of a change in legislation, annual reports must be tabled one month earlier than last year. This year the tabling date is August 27, 2002. As a result, in some places throughout this report, data from the fiscal year 2001-02 was not yet available at the time of printing. In many places, we have had to rely on either draft figures (which are noted) or on the most recent information available from a previous year.

Key Activities

The Action Plan for Saskatchewan Health Care

In December 2001, the government released *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care.* The health plan was the result of many months of careful study and consultation. It was built on the findings of the Fyke Commission on Medicare, the Saskatchewan Legislature's Standing Committee on Health Care, and on the thoughts and opinions of thousands of residents from across our province.

These residents made it clear that they continue to believe in a publicly funded health system that provides care regardless of people's ability to pay. They said that they are proud of a Medicare system that was created here in Saskatchewan some 40 years ago. They want to improve and strengthen it for the future, but they recognize that this will require change.

The resulting health plan is a comprehensive blueprint to secure the future of our health system. It seeks to address immediate challenges in the system, while providing a long-term vision to guide future decisions and investments. While doing so, it adheres to a clear vision: building a province of healthy people and healthy communities.

To achieve this vision, the health plan outlines four key goals:

Provide better access to health care services, including primary, hospital and emergency care;

Improve health workplaces and address shortages of key health providers;

Support good health and the prevention of illness for all Saskatchewan people; and

Improve quality, efficiency and accountability measures to ensure long-term sustainability of our Medicare system.

To address these goals, the health plan outlines a number of specific actions and initiatives for the short, medium and longer term. These key actions are to:

- Establish primary health care teams of doctors, nurses and other health providers.
- Create a 24-hour toll-free telephone line offering immediate access to health advice.
- Create a province-wide network of community, northern, district, regional and provincial hospitals with clear service expectations for each category.
- Improve management of surgical waiting lists to ensure fair, timely access to surgery for Saskatchewan people.
- Provide $3 million in new funding to train more health providers and to offer return-service bursaries for students studying in selected health programs.
- Provide funding to train 240 ambulance attendants to become emergency medical technicians.
- Improve province-wide planning and reduce duplication by forming 12 regional health authorities to replace the current 32 health districts.
- Create Canada's first Quality Council, to promote excellence and effective health spending.
- Increase support for health research in Saskatchewan to help encourage more effective, evidence-based health care.

Readers will see many of these actions, as well as the underlying goals reflected in Saskatchewan Health's 2002-03 Performance Plan which is included, for the first time, in our annual report.

While the department will continue to make progress on implementing the health plan in this fiscal year, it is important not to overlook that a number of steps were already taken during 2001-02. These steps, such as the appointment of Planning Committees to serve in the 12 new regional health authorities, are noted throughout this annual report.

The full text of the health plan is available on the Saskatchewan Health web site at www.health.gov.sk.ca. Copies of the report are also available by calling the department's toll-free inquiry line at 1-800-667-7766.

Key Activities

Tobacco Control

Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year.

A highlight for Saskatchewan Health was the proclamation in March 2002 of the *Tobacco Control Act*. This groundbreaking legislation is designed to protect, and hopefully prevent, young people from becoming addicted to cigarettes. Highlights of the regulations include:

- Prohibiting the provision of tobacco and tobacco products to those under the age of 18;
- Banning the sale of tobacco in health care facilities and schools;
- Restricting tobacco vending machines to age-restricted establishments and requiring them to be five metres from the inside entrance;
- Establishing fines against retailers and employees who sell tobacco to persons under 18 and, in the case of multiple convictions, establishing a temporary prohibition on the retailer's right to sell tobacco;
- Prohibiting tobacco displays, signage and promotional materials where tobacco is sold unless the location is age-restricted;
- Accepting only provincial or federal government-issued photo identification as proof of age when purchasing tobacco;
- Prohibiting smoking in enclosed public places where young people under the age of 18 have access including family childcare homes during hours of business and long term care facilities except in a separate designated smoking room;
- Phasing in the percentage of non-smoking areas in restaurants, bars, bingo halls, casinos, billiard halls and bowling centres over the next three years up to a minimum of 60 per cent by January 1, 2004;
- Providing municipalities with sole responsibility for smoking bylaws which exceed provincial standards, including the power to restrict smoking in restaurants, bars, casinos, bingo halls, billiard halls and bowling centres; and
- Establishing an exception to application of the legislation for the use of tobacco products for traditional First Nations and Metis spiritual and cultural uses.

As part of these new rules, vendors are required to display only signage supplied and approved by the provincial government, as well as signage authorized under the federal *Tobacco Act*. Saskatchewan Health also provided signage for the smoke-free public place provisions of the Act.

Smoking Trends

As a performance indicator, the Canadian Community Health Survey has tracked the number of current smokers over age 12 who reported they were current smokers at the time they were interviewed.

Saskatchewan's rate of current smokers[1] declined from 29 per cent in 1994/95 to 27 per cent in 2000/01. A similar trend is seen at the national level where the rate of current smokers declined from 29 per cent in 1994/95 to 26 per cent in 2000/01. The rate of current smokers in Saskatchewan was higher than the Canadian rate from 1996 to 2001.

Percentage of current smokers 12+ years, Saskatchewan and Canada, 1994-2001

Overall, males continue to have a greater likelihood of smoking than females. In 2000/01, 28 per cent of Saskatchewan males aged 12

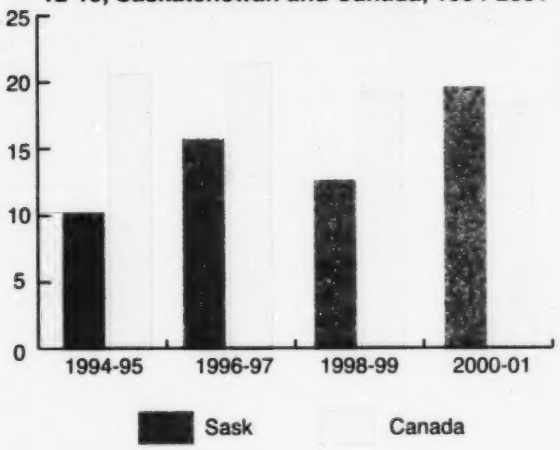
[1] Current smokers are those who smoke on either a daily or an occasional basis.

and over were current smokers compared with 27 per cent of females. The rate of teen female current smokers was higher (21 per cent) than their male counterparts (18 per cent), continuing a national trend which has been observed since 1994/95 (ACPH, 1999b).

Because of the addictive nature of nicotine, youth smoking is of particular concern. It is estimated that approximately eight out of every 10 people who try smoking will become habitual smokers. The Canadian Community Health Survey asked teenagers between 12 and 19 whether they were current smokers.

The survey found the teen rate of current smokers in Saskatchewan doubled from 10 per cent in 1994-95 to 20 per cent in 2000-01. At the national level, the rate of teen current smokers declined from 21 per cent in 1994-95 to 19 per cent in 2000-01.

Percentage of youth current smokers aged 12-19, Saskatchewan and Canada, 1994-2001



In 2000-01, Saskatchewan had the fifth highest rate (20 per cent) in Canada of youth current smokers. Saskatchewan's rates for both youth current and daily smokers were higher than the national averages of 18 per cent and 13 per cent, respectively.

Kicking the Habit

Long-term smoking has well-recognized health consequences that place an added burden on our health resources. Saskatchewan Health acknowledges that many people who smoke may want to quit but need help. In 2001-02 the Department supported a variety of cessation and public education programs for teens and adults including:

Kick the Nic –
A teen smoking cessation program adapted with Saskatchewan content from British Columbia.

Tobacco Cessation –
An integrated approach satellite training workshop. This January 2002 workshop featured renowned tobacco cessation researcher Dr. Paul McDonald. It was broadcast out of Saskatoon to 22 sites in Saskatchewan, and numerous other sites in British Columbia, Alberta, Manitoba and Newfoundland;

Don't Be a Butt –
Saskatchewan Health provided funding for the Saskatchewan Lung Association to hold a series of one-hour health education programs. They are designed for students in grades 5-8, especially in rural areas;

Students Working Against Tobacco (SWAT) –
Received a grant from Saskatchewan Health to educate peers about tobacco use and to promote a lifestyle free of tobacco.

Retention and Recruitment

Supporting, attracting and retaining skilled health professionals is one of the most significant challenges for Saskatchewan's health care system. Many of these health care workers are in short supply, and there is competition for their services, not just within Canada but across North America. Attracting and keeping key health care providers are top priorities and Saskatchewan Health, in partnership with the Saskatchewan Medical Association, continues to look for solutions to these challenges.

Physicians

Saskatchewan Health has continued to seek innovative methods of keeping our doctors in the province, and encouraging new physicians to call Saskatchewan home. These include a variety of incentives such as:

Key Activities

- **Specialist Recruitment and Retention Program**. Under this program, 35 bursaries of $18,000 each were awarded in 2001-02 to residents in specialty training at the University of Saskatchewan. Sixteen of these award recipients are in their final year of training and will be eligible to practise in Saskatchewan as of July 2002;

- **Specialist Emergency Coverage Program.** This program was implemented in July 2001 to compensate specialists for being available (on-call) to provide emergency medical services for new or unassigned patients. This program is administered collaboratively by Saskatchewan Health, the Saskatchewan Medical Association and health districts.

- **Long Service Retention Program.** A $4 million fund was negotiated as part of the 2000-03 agreement between the Saskatchewan Medical Association (SMA) and government. This money will be used for a program to recognize physicians who provide 10 or more years of service to the province. The details of the program will be determined through a joint process with the SMA.

- **International Medical Graduate (IMG) Assessment Pilot Project.** Saskatchewan is piloting a new project to evaluate foreign-trained family physicians not currently eligible to be licensed in Saskatchewan. The College of Physicians and Surgeons developed the project, in co-operation with the College of Medicine, the Saskatchewan Medical Association and the Government of Saskatchewan. Saskatchewan Health provided $85,000 for the project. Candidates must agree to a return-service commitment in an area of need in Saskatchewan.

- **College of Medicine increased funding.** In September 2001, the number of undergraduate seats in the College of Medicine was expanded from 55 to 60. The expansion will provide an opportunity to train more physicians and return medical school enrollment to the 1994 level. A sustainable, incremental approach to increasing enrollment is one part of an overall strategy to increase the supply of physicians in Saskatchewan.

Other Health Care Providers

Providing the quality, accessible services that Saskatchewan people depend on requires a stable supply of many key health providers. As outlined in the Action Plan, Saskatchewan Health is devoting $3 million in new funding to implement bursary programs and other initiatives to retain and recruit these providers. Additional funding will be provided to train emergency medical technicians and primary care nurse practitioners.

Bursaries are offered to a number of hard-to-recruit health disciplines like occupational therapy, physical therapy, respiratory therapy, audiology, psychology, speech language pathology and public health inspection. These bursaries are offered in exchange for return-service agreements. For example, a student in physical therapy could receive funding while going to school, if he or she agrees to work in the province in the publicly-funded system for a pre-determined length of time after graduating.

These initiatives are starting to show promising results as detailed in the section *A Strong Workforce*.

Surgical Waiting Lists

In January 2002, Saskatchewan Health released a comprehensive report on surgical wait lists. *Surgical Wait List Management: A Strategy for Saskatchewan* outlined a number of recommendations to improve the wait list system, provide better public information, and to ensure patients have fair, timely access to surgery.

The preliminary findings of this report were used to help develop the wait list strategy outlined in the province's health plan. Specific actions that were recommended include:

- Improve surgical capacity by continuing to retain and recruit key health providers and provide special wait list funding to select health regions.

- Create a province-wide surgical waiting list to track all patients needing surgery in the province.

- Establish benchmark waiting times (targets) for the various urgency rankings so patients know the maximum time they should be waiting.

Key Activities

- Provide clinical tools to help physicians rank their patients' need for surgery on a consistent, province-wide numerical scale. This will ensure those who need surgery the most receive it first.

- Create a patient web site to provide information on the surgical system and help people ensure the shortest possible wait.

- Provide the public with key contact people in Regina and Saskatoon who can provide information on their waiting time for surgery through a toll-free phone number.

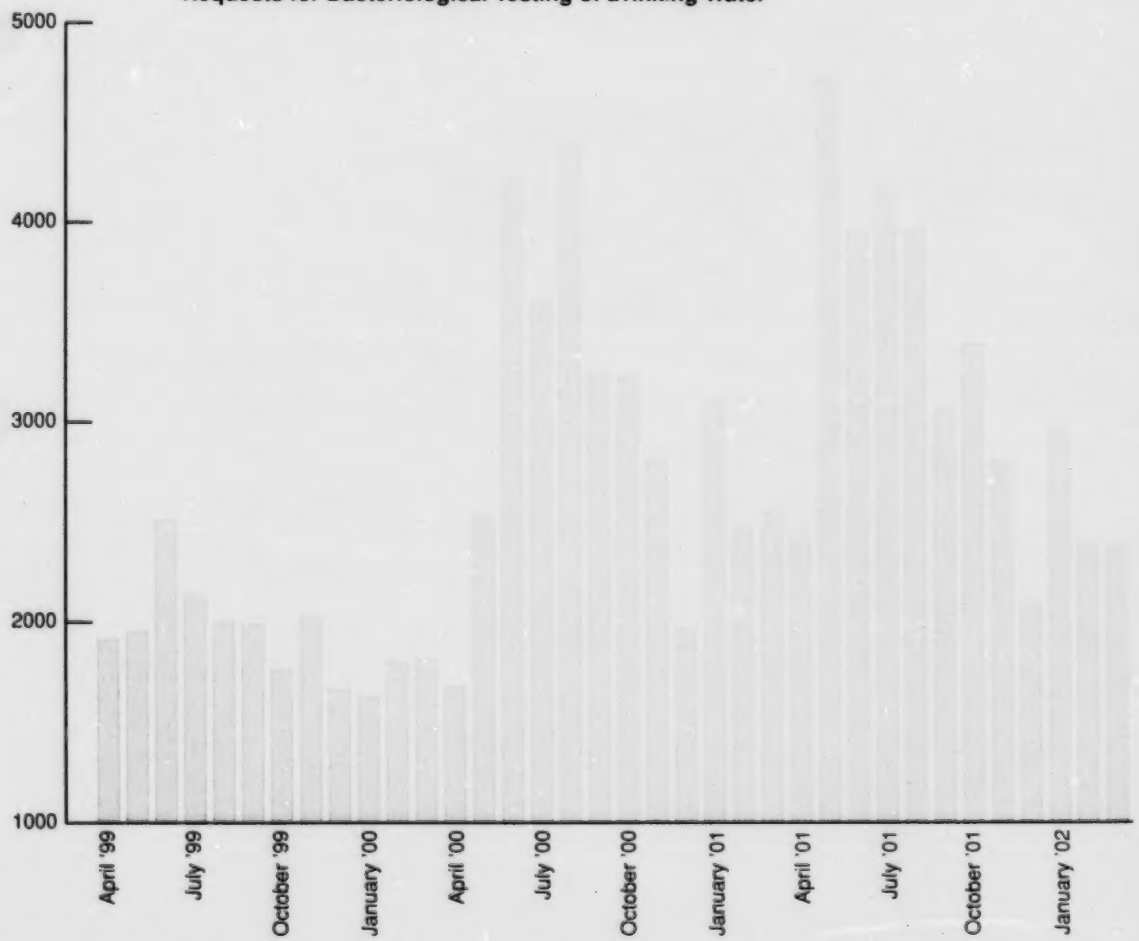
The report also recommended the creation of the Saskatchewan Surgical Care Network (SSCN). This committee was created by Saskatchewan Health late in 2001-02. It includes representatives of health providers, health districts, government, the public and other agencies. This network will ensure that the various partners work closely together to implement strategies for wait list management outlined in the health plan.

Further details about surgical volumes and waiting times in 2001-02 can be found in the section *Improving Quality and Accessibility*.

North Battleford Water Inquiry

In April of 2001, a large number of people in the North Battleford area developed a gastrointestinal illness that was later traced to a cryptosporidium outbreak in the municipal water supply. Saskatchewan Health provided public health advice and technical assistance to the Health District, to Saskatchewan Environment and Resource Management, and to the City of North Battleford in the management of the outbreak.

Requests for Bacteriological Testing of Drinking Water



Key Activities

At the time of the outbreak, Saskatchewan Health also co-ordinated enhanced surveillance efforts in this province and across the country for cases associated with this outbreak.

In addition, the department immediately called on Health Canada to conduct a comprehensive epidemiological study to determine the exact cause of the outbreak. The final report became a pivotal document in the subsequent government ordered inquiry into the North Battleford outbreak.

The final report of the Inquiry was released on March 28, 2002. It contained several recommendations for Saskatchewan Health that will be addressed in 2002-03 in collaboration with regional health authorities.

The North Battleford outbreak was one example of how our water supplies can be vulnerable to contamination. The earlier e-coli contamination of the water supply in Walkerton, Ontario was another high-profile example that caused many people to think more critically about the safety of their water supply. Following this outbreak there was a sharp increase in the number of Saskatchewan people who submitted private water supply samples to the Provincial Laboratory for bacteriological testing. The graph "Requests for Bacteriological Testing of Drinking Water" illustrates the number of samples submitted for bacteriological testing at the Provincial Laboratory from May through January in the 1999-2000 and 2000-2001 fiscal years.

In addition to the outbreaks in Walkerton and North Battleford, the flood that occurred in the Vanguard, Saskatchewan area in 2000 also resulted in a larger number of samples being submitted for testing.

Problem Gambling in Saskatchewan

In March 2002, Saskatchewan Health released the 2001 Problem Gambling Prevalence Survey. The study was based on a newly-developed national research tool called the Canadian Problem Gambling Index. Using this tool, the report classified 1.2 per cent of Saskatchewan adults as problem gamblers, 4.7 per cent as moderate risk gamblers, 9.3 per cent as low risk gamblers and 71.4 per cent as non-problem gamblers. The study identified a number of demographic groups who are at greater risk for developing a problem. They include young adults (19-24 years) and gamblers with lower levels of education and lower incomes. Copies of the report are available on the Saskatchewan Health website at www.health.gov.sk.ca.

Classification of Saskatchewan Adults by Gambler Sub-Type

Gamblers Sub-Types	% of Sask. Adults
Non-gamblers	86.6%
Non-problem gamblers (PGSI=0)	71.4%
Low risk gamblers (PGSI=1-2)	9.3%
Moderate risk gamblers (PGSI=3-7)	4.7%
Problem Gamblers (PGSI=8+)	1.2%

PGSI= Problem Gambling Severity Index.

Source:
Gambling and Problem Gambling in Saskatchewan (2002)

Saskatchewan Health is responsible for delivering or co-ordinating problem gambling prevention and treatment programs across the province. The study was done to help the department and its partners improve their understanding of the scope and nature of problem gambling in the province, and to make comparisons with other jurisdictions.

Prior to the release of the report, in July 2001, the budget for problem gambling prevention and treatment was increased by $1.25 million, bringing total program funding to $2.75 million.
The new funding is supporting additional prevention and education programs targeted to post-secondary students and seniors, a broad public awareness campaign, research into problem gambling, new treatment programs, additional counselors in the Regina and Saskatoon Health Districts and enhanced training for staff. In addition, some community organizations have applied for a portion of the funding to develop and deliver local prevention and education programs.

Key Activities

Emergency Preparedness

On September 11th, 2001, terrorists crashed two jet airliners into the World Trade Towers in New York. A third plane hit the Pentagon in Washington, D.C., while a fourth went down in a field in Pennsylvania.

This served as a reminder that however remote the possibility, the potential for destructive acts must be considered in our emergency preparation. Prior to September 11, Saskatchewan Health had already been working with a number of federal, provincial, and local agencies to develop and implement policies and procedures for such emergencies.

As a result of the anthrax attacks in the United States and fears over the large number of "suspicious packages", Saskatchewan Health, with the assistance of many partners and other agencies, developed the *Interim Health Response Guidelines for "Packages of Concern"*. These guidelines were developed for response personnel in the health districts.

The Provincial Lab was also a key component in handling suspicious packages in Saskatchewan by providing expertise on sample evaluation, ensuring safe packaging, transport and reporting results of samples submitted to the National Microbiol Laboratory in Winnipeg.

Other initiatives included additional training for our Emergency Response Assistance Program team to include response to bioterrorism events and handling of high risk human pathogens. Our provincial specialists provided advice to Health Canada on acquisition and deployment of essential pharmaceuticals and vaccines.

The Federal/Provincial/Territorial Conference of Deputy Ministers of Health has established a special task force on emergency preparedness and response. The goal of this committee is to provide recommendations and develop an action plan that will ensure seamless emergency preparedness and a co-ordinated response in the health sector. Through on-going risk assessment, Saskatchewan Health will continue to work with other organizations to develop a response system that is effective and appropriate should an emergency situation arise in Saskatchewan.

Research

Health research is a vital component of effective health care. To ensure quality, effective and accountable health care, we need to base our decisions about programs and services on sound research and data. Since the Saskatchewan Health Services Utilization and Research Commission (HSURC) was established in 1992, it has developed a number of clinical practice and other service guidelines which have led to more appropriate use of health services (e.g. use of routine admission tests and use of day surgery). HSURC has also administered research grant competitions funded by Saskatchewan Health in support of the development of health research in the province. The provincial government funds a wide range of health research to improve our knowledge about how best to preserve, protect and promote the health of Saskatchewan residents.

While Saskatchewan Health has always recognized the importance of health research, that commitment was strengthened in 2001-02 when *The Action Plan on Saskatchewan Health Care* promised to substantially increase funding support for health research in the coming years. The 2002-2003 provincial budget released at the end of March 2002 included an 80% increase in health research funding. As well, a newly created Saskatchewan Health Research Foundation will organize, manage and allocate most provincial health research funding in Saskatchewan.

Promoting Good Health

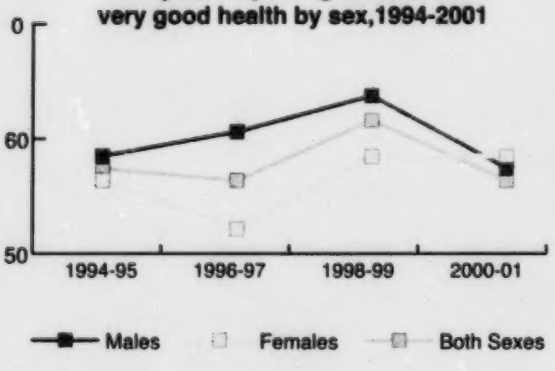
Maintaining a healthy population and a healthy province relies on much more than having a doctor or hospital nearby. A wide range of factors such as level of income, education, quality housing, nutrition and social networks can all have a profound impact on an individual's health. These broader "determinants" of health can affect not only a person's health, but also their level of dependence on the health care system.

Saskatchewan Health supports a variety of population health promotion initiatives. There are many things we can do to prevent or lessen health problems, instead of just reacting to them after the fact. *The Tobacco Control Act*, aimed at reducing youth smoking rates, is a good example of provincial policy aimed at preventing the negative health effects of tobacco use.

Measuring our Health

How successful are we at keeping our population healthy? One way to assess the health of a population is to ask people how they perceive their own health status through population health surveys. This is a highly subjective measure, which may depend on an individual's outlook on life as well as health status. At a population level the measure is an important indicator of the health of a population and is strongly related to other health measures such as the incidence of chronic diseases and even mortality.

Saskatchewan percentage of persons 12+ years reporting excellent or very good health by sex,1994-2001



Source:
Canadian Community Health Survey – Cycle 1.1 – 2000/2001

The "self-reported health" indicator represented here is the per cent of the population age 12 and over who report that their health is very good or excellent.

Since the initial results of the National Population Health Survey in 1994 the per cent of the population rating their health as excellent or very good peaked in 1998-99, and subsequently dropped again in 2000-01.

Provincial Comparisons

When looking at any kind of performance or health status measure, it can be helpful to note how Saskatchewan compares to other parts of the country. In 2000-01, 57 per cent of Saskatchewan residents aged 12 years or older reported their health as excellent or very good, compared to 66 per cent of Newfoundland residents (the highest proportion) or 55 per cent of New Brunswick residents (the lowest proportion to report their health as excellent or good).

Life Expectancy

Life expectancy is a widely used indicator of the health of a population. While the health system can play a role in determining length of life, socio-economic factors such as poverty and education levels also have a major effect.

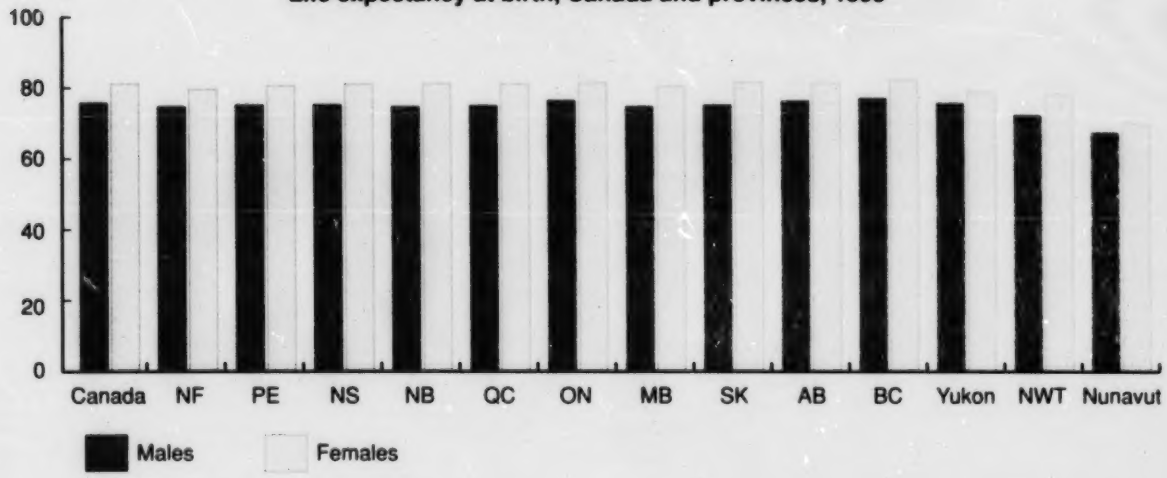
Life expectancy at birth estimates the number of years a person born today would be expected to live.

In the most recent data available between 1979 and 1999, life expectancy at birth increased 2.5 years to 78.5 years. Generally, females have a greater total life expectancy than males. In 1999 female life expectancy was 81.8 years and the male life expectancy was 75.4 years. However, the gap in life expectancy between the sexes continues to narrow.

Provincial Comparisons

In 1999, Saskatchewan had the fourth highest (78.6 years) life expectancy at birth of all the provinces. The national average was 78.3 years.

Life expectancy at birth, Canada and provinces, 1999

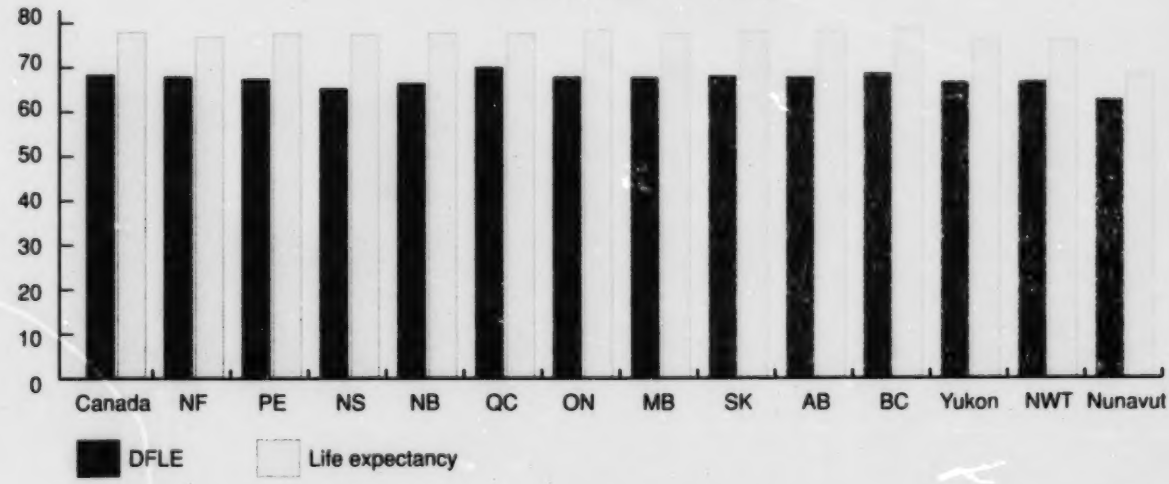


Source: Statistics Canada, Vital Statistics, Death Database and Demography Division (population estimates)

Disability-free Life Expectancy (DFLE)

While life expectancy may measure the total years people may live, it does not measure their "quality" of life. Disability-free life expectancy at birth is the number of years an average individual would be expected to live free of moderate or severe disability. This estimate is based on the mortality statistics and disability prevalence patterns by age and sex for a given observation period, typically a calendar year.

Disability free life expectancy, in relation to total life expectancy at birth, Canada and provinces, 1996



Source: Statistics Canada, Vital Statistics, Death Database and Demography division (population estimates), and the 1996 Census (20 per cent sample).

DFLE is a health status indicator developed to reflect the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty or disability tends to become more prevalent at older ages, so a population with a higher life expectancy may not be healthier. If life without any disease or disability is increasing more rapidly than life expectancy, then not only are people living longer, but they are also living a greater portion of their lives in relatively good health.

Provincial comparisons

In 1996, Saskatchewan had the third highest (68.3 years) DFLE at birth of all the provinces. The national average was 68.6 years. DFLE is presented in a table on the previous page in relationship to overall life expectancy.

Infant Mortality

Infant mortality is defined as the number of infants who die in the first year of life, expressed as a rate (per 1,000 live births) for a given year.

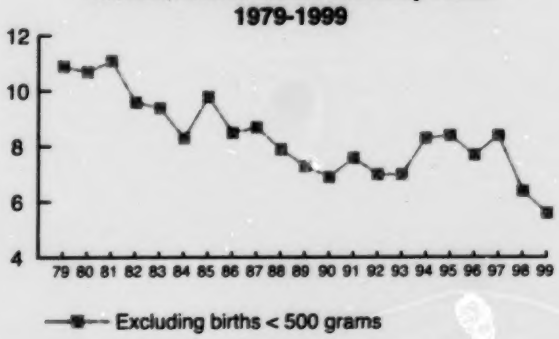
The infant mortality rate is a long-established measure of infant health and the health status of a society. It reflects not only the level of mortality, but also the health status and health care of a population. A high infant mortality rate in a population can be a reflection of deficiencies of physical and socio-economic factors such as nutrition, socio-economic status, education or health care. The infant mortality rate is also influenced by maternal factors outside of the health system such as education level, age, and smoking.

While this indicator is an effective measure of the health of the population, it does not necessarily reflect the performance of the health system.

In general, the infant mortality rate (IMR) in Saskatchewan has been declining. However, a slight increasing trend was evident between 1992 and 1995. The annual IMR has fluctuated over the 20-year period from a high of 11.1 deaths per 1,000 live births in 1981, to a low of 5.9 deaths per 1,000 live births in 1999.

Because of possible provincial differences in the registration of live births of extremely low birth weight (under 500 grams) in earlier years, and the reduced chances of survival of such infants, they are excluded from the calculation of infant mortality rates to allow for better comparisons over time.

Saskatchewan Infant Mortality Rates 1979-1999



Source: Statistics Canada Catalogue 84F0210XPB, Births and Deaths Statistics Canada web site.

Provincial Comparisons

Of all the provinces, Saskatchewan had the second highest male infant mortality rate for birth weights excluding those < 500 grams (6.4 deaths per 1,000 live births) after Manitoba (7.6 deaths per 1,000 live births). The Saskatchewan rate was higher than the national average (4.9 deaths per 1,000 live births). Saskatchewan had the third highest mortality rate for females (4.9 per 1000) after P.E.I (5.6) and Manitoba (5.1).

With the exception of Newfoundland and Prince Edward Island, all provinces had a higher infant mortality rate for males than for females in 1999.

Low Birth Weight

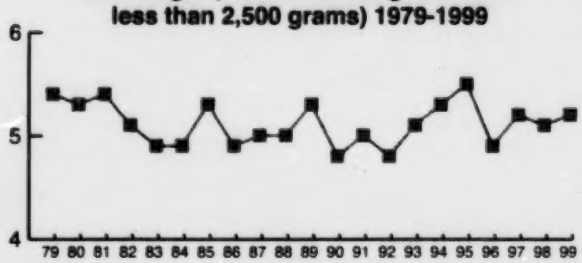
Low birth weight is an indicator of the general health of newborn babies and a key determinant of infant survival, health and development. Low birth weight is defined as the proportion of live births with a birth weight greater than 500 grams and less than 2,500 grams.

Low birth weight infants are at a greater risk of dying during the first year of life, and if they survive, they have a greater risk of disability such as cerebral palsy, visual problems, learning disability and respiratory problems. Low birth weight is associated with poor maternal health, lifestyle and economic circumstances. It is also associated with multiple births and assisted conception.

The low birth weight rate in 1997 in Canada was 5.8 per cent of all live births. In Saskatchewan, the rate was 5.2. Among developed countries, a rate of less than 5.0 is considered good.

There was an overall decrease in the Saskatchewan percentage of low birth weight babies between 1979 and 1999, however, during this 20 year period there has been fluctuations in the rate.

Percentage of Saskatchewan live births with low weight (More than 500 grams and less than 2,500 grams) 1979-1999



Source: Statistics Canada, Vital Statistics, Birth database

Reducing the Risk of Infant Deaths

A number of factors can affect the risk of infant deaths. For example, levels of employment, housing, education, family supports and socio-economic status contribute to health generally and can also influence the risk of infant deaths. Other factors such as infection and disease during pregnancy, poor nutrition, smoking and substance abuse also play an important role. Achieving healthy outcomes in the population therefore requires a multi-sectoral approach.

An estimated 300,000 doses of vaccine were administered to about 75,000 children in 2001-02 to protect them from infectious diseases.

The government has made significant investments in early childhood development, particularly since the introduction of the Child Action Plan in 1993. The Child Action Plan is a major inter-departmental strategy to enhance the well being of Saskatchewan children, youth and families.

More recently, the government launched the *Kids First Program*. This program is focused in a number of targeted communities, as well as northern Saskatchewan. It provides intensive early childhood supports to vulnerable children from birth to age five, as well as their families.

Saskatchewan Health continues to work in collaboration with health districts, other government departments and other agencies to improve infant health. Health initiatives include the establishment of a provincial infant/perinatal health co-ordinator, public and professional education to prevent infant injuries and deaths and funding to health districts for programs that address high infant mortality rates.

In addition, the *Family Health Benefits Program* provides additional health benefits to lower income families, removing financial barriers to important services.

The services and benefits provided through these initiatives help to address factors that contribute to improved health of children and infants and to reduced infant mortality.

Promoting Good Health

Drinking Water

An adequate supply of clean drinking water is vitally important to good health. During 2001-02, a Provincial Government Long Term Drinking Water Strategy was developed by Saskatchewan Health in partnership with Saskatchewan Environment and Resource Management, Sask Water Corporation, Municipal Affairs and Housing, and Saskatchewan Agriculture and Food. The strategy includes measures to enhance safety requirements for semi-public drinking water systems that fall under the jurisdiction of health districts (ultimately health regions).

Public Health

In October 2001, Saskatchewan Health released the document *Public Health/Population Health Services* in Saskatchewan. This document was developed with assistance from health district CEOs and public health professional groups. It provides guidelines for regional health authorities to develop priorities for public health programs suitable to local needs.

The document identifies public health programs and activities such as:

Healthy Families: healthy birth outcomes, healthy child development, dental disease, food security, child abuse prevention, prevention of high-risk behaviours in youth, healthy sexuality, decreasing social isolation in seniors;

Chronic Disease Prevention: physical activity, tobacco use reduction, good nutrition, substance abuse prevention, stress management;

Safe Communities/Environments: safe food and water, safe living conditions, hazard reduction, disaster planning and response, injury prevention, violence reduction;

Communicable Disease Control: immunization, communicable disease control, STD control, outbreak control, TB control, infection control, travel medicine.

Response from health districts indicated that this document will help to define and clarify the role of public health programs at a time of proposed changes to the health system. The intent is that this publication will serve to guide health regions' decision making in order to achieve better health outcomes with the limited resources available.

Provincial Laboratory

The Provincial Laboratory provides public health, water quality and reference testing services. It also provides population health surveillance data for infectious and communicable diseases, ensuring early detection of outbreaks and timely public health intervention. Each day the Provincial Laboratory receives two to three thousand specimens and sends out approximately 6000 reports.

Some highlights of the initiatives undertaken by the laboratory in this fiscal year include:

- Identified the North Battleford Cryptosporidium outbreak through routine testing;
- In December 2001, an E. coli outbreak was identified at a Regina restaurant. This allowed public health officials in Regina Health District to implement timely intervention to prevent further spread of the disease;
- Developed new methods to measure anti-convulsant drugs to help physicians monitor patients with epilepsy;
- Developed a novel and specific DNA fingerprinting process which will assist in future outbreak investigations and province-wide surveillance of bacteria; and
- Provided 72 clinical specimen totes for use in 24 medical facilities throughout the province. The totes are used to transport diagnostic specimens to the Provincial Laboratory in a safe and timely manner. This means there are fewer repeat samples necessary and turnaround times are markedly reduced.

Promoting Good Health

Diabetes

Diabetes is a growing concern within Saskatchewan. Figures across North America seem to indicate that as trends toward obesity rise, so also do the numbers of people suffering from diabetes.

Saskatchewan Health has developed a provincial plan for the control of diabetes that is made up of four components:

- Surveillance;
- Diabetes prevention;
- Education; and
- Care and treatment.

This provincial plan introduces a team approach for the provision of diabetes education care and treatment, recognizing that the individual with diabetes is ultimately responsible for self-management of the disease. To support a team approach within the Regional Health Authorities, the department's Primary Health Services Branch allocated $530,000 to:

- Develop regional diabetes teams to improve access to services;
- Submit regional proposals to Saskatchewan Health outlining how the teams would deliver services;
- Purchase computer equipment for communication and development of a regional database; and
- Assess the extent of undiagnosed diabetes among First Nations, Metis and Non-First Nations in select communities identified as being at higher risk for diabetes.

An educated workforce is a valuable asset in the fight against diabetes. Through the Saskatchewan Institute of Applied Science and Technology (SIAST), Saskatchewan Health is supporting an enhanced diabetes education program. SIAST is also developing materials for "Risk Identification of the Foot in Diabetes" to be delivered in each health region.

Build Better Tomorrows

In February 2002, Saskatchewan played host to more than 320 people from several provinces for the Build Better Tomorrows Conference in Saskatoon. The conference explored how communities are using population health promotion approaches to create the conditions that support health and help to prevent diabetes.

Diabetes Surveillance

At a national level, Saskatchewan continued to participate in the National Diabetes Surveillance System. This is a system of consistent codes that will facilitate interprovincial comparison of the incidence and prevalence of diabetes. This information will present a clearer picture of the exact scope and nature of diabetes in Saskatchewan and in Canada. This, in turn, will assist in program planning for diabetes control and will allow us to track our progress and check it against other parts of the country.

Improving Quality and Accessibility

As of June 30, 2001, there were 1,024,788 people eligible for insured health services in Saskatchewan. Through the health registration process, the Health Registration and Vital Statistics Branch maintains a central registry of all residents eligible for provincial health benefits and a central registry of all vital events including births, stillbirths, deaths, marriages and legal changes of name occurring in Saskatchewan. In fact, this branch is often the most frequent point of contact with Saskatchewan Health for the general public. In this fiscal year, staff handled more than 220,000 phone calls and issued nearly 170,000 health services cards and vital event documents.

Further details on vital statistics in Saskatchewan can be found in the Saskatchewan Health Vital Statistics Interim Annual Report, available from Saskatchewan Health or online at www.health.gov.sk.ca.

Primary Health Care

When people talk about *accessible* health care, they are often thinking of the everyday health care services that they use in their community such as going to the doctor's office, or getting immunizations for a child, getting advice on how to manage diabetes or talking to a nutritionist. All of these services are part of *primary health care.*

The provincial government recognized several years ago that primary health care must be a priority. *The Action Plan for Saskatchewan Health Care* reaffirmed the government's commitment to primary health care reform by outlining a team-based approach to be implemented across the province over the next ten years. The plan emphasizes improved access and co-ordination of resources. They include goals like:

- Building stronger teams of health and non-health professionals;
- Improving the co-ordination of services provided by regional health authorities;
- Linking physician services with regional health authorities;
- Making sure programs and services are geared for the people who most need them;
- Focusing on preventive care; and
- Bringing in new programs and approaches that will lead to improvements in health.

Primary health care promotes service delivery through a team approach. These teams can include doctors, nurses, therapists, pharmacists, nutritionists and other front-line providers. The team can also include people from outside the traditional health professions, such as education, social services, justice, municipal government and the community, reflecting the many broad factors that can influence our health.

24-Hour Telephone Advice Line

As part of *The Action Plan for Saskatchewan Health Care*, the government announced, in December 2001, plans to establish a 24-hour telephone advice line. This service will allow Saskatchewan residents to talk to specially trained nurses at any time of the day or night. The nurses will assess callers' symptoms and advise them on where to go for help, or how to manage their condition at home. This help line will ensure callers receive timely advice, and direction to the most appropriate source of care.

Saskatchewan Health has issued a Request for Proposals in order to select an organization to deliver the service. The advice line should be available in the spring of 2003.

Hospital Services

As of March 31, 2002, there were 66 acute care hospitals, one rehabilitation hospital, and 79 health centres* operating throughout Saskatchewan. (*Hospitals in Hafford, Uranium City, Wawota and Turtleford have been operating as health centres).

During 2001-02, the government introduced a new hospital classification system for Saskatchewan. As detailed in the government's *Action Plan for Saskatchewan Health Care*, this system establishes five new hospital categories that set out a clear structure for hospitals within the larger health system and outlines the minimum level of services to be provided at each type of hospital.

This service delivery framework will help to ensure quality, reliable hospital services and help to guide decisions about where investment is needed to provide core services.

Acute Care Services

- There were more than 130,000 acute care inpatient hospitalizations in 2000-2001.
- The average length of stay in hospital was 5.7 days.
- Half of the hospitalizations were in Regina and Saskatoon, 20 per cent in the six regional hospitals, 11 per cent in the nine district hospitals, and 20 per cent in the community and northern hospitals.

Specialized Hospital Services

Surgical Services

While surgery is provided in a number of communities across Saskatchewan, most surgery is done in larger centres with more highly specialized hospitals. To illustrate, approximately 71 per cent of all surgeries are performed in the provincial hospitals in Regina and Saskatoon, with most of the remaining surgeries done in the six regional hospital centres – Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster. Overall, 94 per cent of surgeries are done in these eight communities.

The total number of surgeries performed in 2000-2001 (the most recent year for which figures are available at time of printing) was approximately 93,000. This is similar to the volumes of surgery done in the previous two years.

Surgical programs are broad in scope and complex in nature. The availability of good, comparative data on surgical procedures is improving through initiatives such as the Canadian Institute for Health Information's health indicators project, which has identified a number of surgical indicators. For most procedures, however, there are no benchmark rates that indicate how many procedures should be done.

One of the characteristics of surgery that has changed over the years is the length of time a patient needs to stay in hospital after the procedure. More and more routine surgeries can be done as day surgery. This means a patient can arrive at the hospital, have a surgery done and leave – all in the same day. The proportion of day surgery in relation to the total surgical cases continues to grow. While total surgery volume has grown by about 11 per cent over the past ten years, within that total, inpatient cases dropped by about 31 per cent while day surgeries saw an 85 per cent increase during that time.

Source of Surgery Trend Chart

Surgical Separations

	Inpatient Surgery	Day Surgery	Total
1990-91	54,204	30,023	84,227
1991-92	53,597	32,879	86,476
1992-93	51,335	34,174	85,509
1993-94	47,140	38,832	85,972
1994-95	44,607	42,488	87,095
1995-96	43,023	41,914	84,937
1996-97	42,154	45,224	87,378
1997-98	41,683	50,090	91,773
1998-99	39,912	53,890	93,802
1999-00	38,030	55,426	93,456
2000-01	37,583	55,516	93,099

Separations from Saskatchewan hospitals, excluding newborns.

Surgical separations are identified using CIHI's medical/surgical indicator and 1991 list of surgical procedures.

Waiting Times for Surgery

Waiting for surgery can be a stressful experience for both patients and their family members. While surgeons in our province perform 93,000 inpatient and day surgeries a year — an average of 255 every day — there remain a significant number of people who are on a waiting list for surgery.

It is difficult to pinpoint the number of people who are waiting for procedures, given that waiting lists are currently not held in one place and that lists are not consistently verified (e.g. people on lists may not need surgery anymore, or be on more than one list). By the end of 2001-02, there were about 27,000 people on surgical wait lists in Regina and Saskatoon, where more than 70 per cent of surgeries are done.

Who is on the Waiting Lists?

A patient who requires surgery is classified in one of three broad groupings:

1. Emergent – This is an "emergency" situation. The patient needs immediate surgery because of a life-threatening situation. These individuals

will receive surgery as soon as possible. About half of all heart surgery is done on an emergency basis.

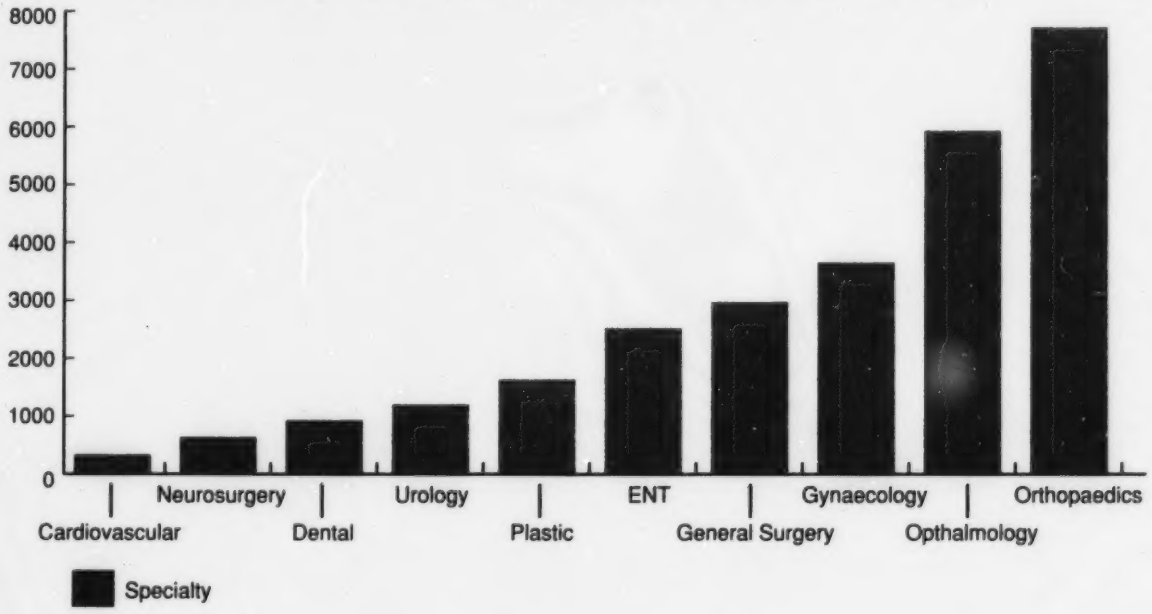
2. Urgent – The patient is not in a life-threatening situation but surgery must be done in a short period of time. All suspected cancer cases are treated as "urgent". Patients in this category are closely monitored by their physicians and can be changed to "emergent" if their condition changes.

3. Elective – The vast majority of people on wait lists are waiting for "elective" surgery. These patients need surgery to improve their health or quality of life. While their condition may be painful or affect their lifestyle, it is not considered an immediate threat to their health or life.

Detailed information on "who is waiting" is currently only available from Regina and Saskatoon. As the following graph shows, a large percentage of the people on lists are waiting for orthopedic surgery (e.g. hip or knee surgery) or ophthalmology procedures (e.g. cataract removals). These procedures typically account for the bulk of the longer waits in our health system, even though they are done at similar age-adjusted rates in Saskatchewan, in comparison to other provinces.

Recent data from the Canadian Joint Replacement Registry (2002 Report) outlines the rates for hip and knee surgeries done in all provinces during 1999/2000. The report shows that Saskatchewan's rate for total hip replacement surgery is the fourth highest and that the rate for total knee surgery is sixth highest among the provinces. Rates for both procedures are above the national average.

Patients Waiting for Surgery in Regina and Saskatoon as of March 31, 2002



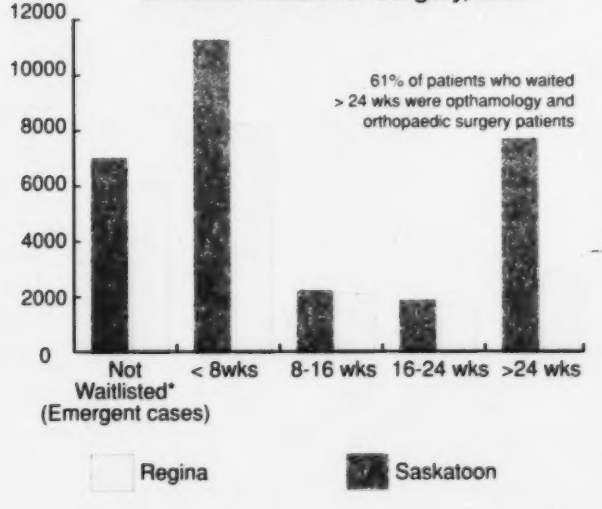
Improving Quality and Accessibility

Waiting Times

While it may be useful to know how many people are on a wait list for surgery, what is more important is how long it will take for each individual to receive their surgery. The scheduling of surgery is an extremely complex undertaking that can be affected by a number of factors. Shortages of key health care providers can affect operating room hours. Sometimes patients who are booked for surgery have to be "bumped" if an emergency case suddenly needs to be handled. Or, some patients may decide themselves to delay their surgery or decide that they are not available during a certain time (e.g. during summer holidays).

Again, data on exactly how long individuals are waiting for procedures in Saskatchewan is still far from perfect. Currently, Saskatchewan Health receives regular figures from the Regina and Saskatoon Health Districts that show the number of patients who have received surgery and how long they waited after being booked for the procedure. Data for the calendar year 2001 shows that the majority of patients who received non-emergency surgery waited less than eight weeks. It also shows that the majority of the patients with the longest waits (e.g. 61 per cent of patients who waited more than 24 weeks) received eye surgery or orthopedic surgery.

Cases to Operating Rooms by Number of Weeks Waited for Surgery, 2001



Making Comparisons:

Often, Saskatchewan people want to know: How do our waiting times for surgery compare to those in other provinces? Unfortunately, this is a difficult question to answer, given the quality of data that is currently available.

For instance, data collection is not yet standardized in our own province, not across the country. For the most part, regions, hospitals and doctors maintain their own wait lists and often use very different methods of collecting and compiling wait list data.

We recognize that reporting to the public on surgical wait times is an important aspect of accountability. We are working closely with health districts/regions, physicians and other health care partners to improve our information collection so we can inform Saskatchewan people about our progress in better managing our province's surgical waiting lists.

Renal Services

The Saskatchewan Integrated Renal Program Steering Committee has the task of improving services available to patients and individuals at risk of end-stage kidney disease. It provides advice to the department and the health districts. A number of changes occurred in 2001-2002 including:

- Hospital based emergency physicians and nurse practitioners now provide some support to nephrologists (kidney specialists) in the dialysis units in Regina and Saskatoon.
- Chronic Renal Insufficiency (CRI) clinics are now in place providing educational sessions and monitoring individuals with reduced kidney function to delay the need for dialysis and to better prepare patients in making their treatment choices - hemodialysis, peritoneal or home dialysis, or transplant.
- Satellite services were expanded in Prince Albert in June 2001 and Yorkton prepared for an expansion for April 2002, providing life-saving services closer to home for some patients.

Improving Quality and Accessibility

- A Dialysis Services Review was undertaken to identify longer-term strategies for delivering and managing renal services, amid rapidly growing demand for these services.

Specialized Medical Imaging

During 2001-02, the Regina Health District expanded its operating times for MRI services and bone mineral density testing services. It is expected that, as applications for the use of MRI continue to expand, demand for this diagnostic test will continue to increase.

In December 2001, the Regina Health District replaced one of its CT scanners with a new multi-slice helical scanner. The new CT scanner is the first of its generation to be installed at a Canadian hospital and is capable of providing faster results.

The scanner was one of the many equipment purchases made with a $33.3 million *Medical Equipment Fund* received from the federal government. All 32 health districts and the Saskatchewan Cancer Agency received a share of the first portion of the fund, amounting to $16.5 million dollars. Some other examples of the equipment purchased by the districts in this fiscal year included:

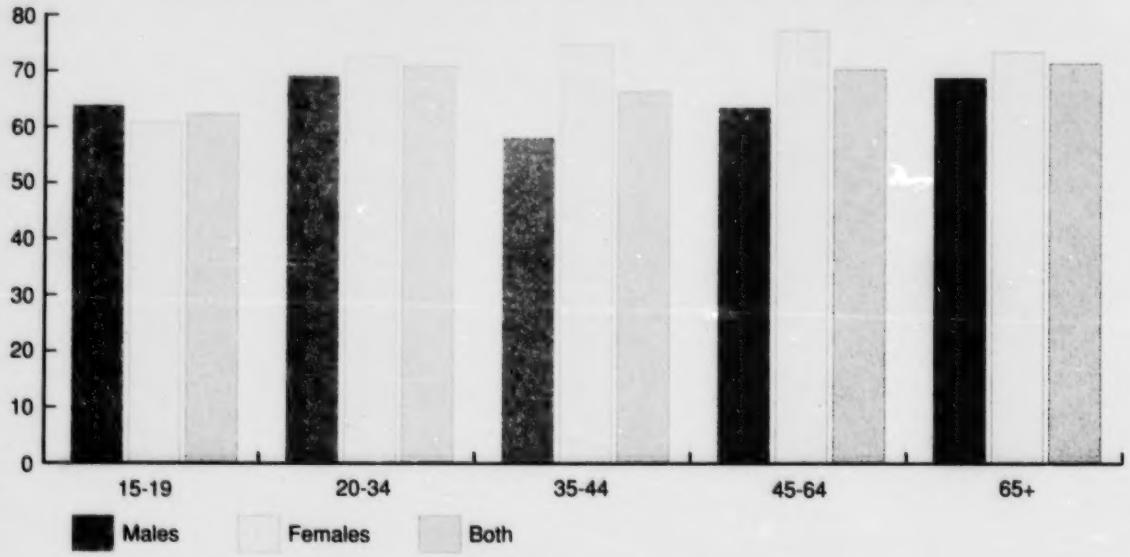
- $7.62 million in diagnostic imaging equipment, including ultrasound, x-ray units and CT scanners;
- $2.89 million for 750 beds in health care facilities;
- $2.44 million in medical/surgical equipment, including anaesthesia machines and surgical lasers;
- $921,000 in laboratory equipment; and
- $481,000 for patient lifts to benefit clients and address work safety issues.

Patient Satisfaction

Ultimately, people will make judgements on the quality of their health care through personal experience, or direct contact with the health system.

Patient satisfaction is being developed as one performance measure for our health care system using the Canadian Community Health survey. This survey included people in private dwellings in

Persons 15+ years receiving health care services in the previous 12 months reporting excellent or good qualityof health care received. Saskatchewan, 2000-01



Source: Canadian Community Health Survey (sub sample approximately 25,000) – cycle 1.1 2000

all provinces and territories over the age of 15. They were asked to rate the quality of health care they received as excellent, good, fair or poor.

Because the reporting of this kind of information is so new there is no historical data available for this indicator.

Services received in a hospital

Percentage of adult population (15+) who report the quality of health care services received in the previous 12 months as excellent or good

In almost all age-sex categories, a higher percentage of Saskatchewan residents, than the Canadian average, reported excellent or good quality of health care services. The percentage of Saskatchewan females who reported excellent or good quality of health care services was generally higher than that of their male counterparts with the exception of the 15 to 19 year old age category. In Saskatchewan as well as Canada, the age group with the highest percentage reporting an excellent or good quality of health care service was the 65 plus age group.

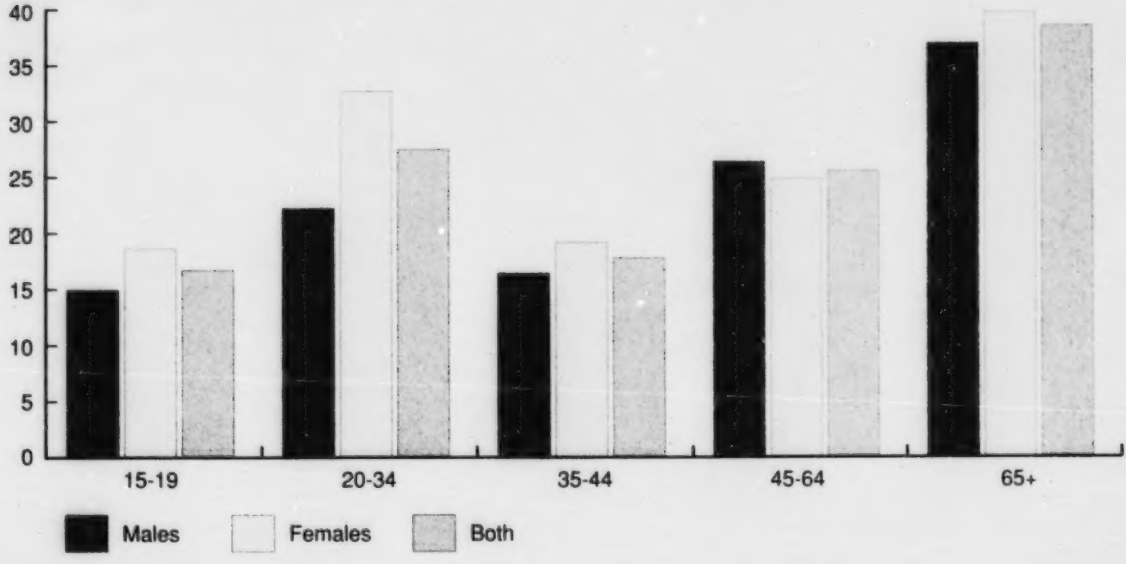
Overall health care services received

Percentage of adult population (15+) who report the quality of hospital services received in the previous 12 months as excellent or good

In most of the age-sex groups, the percentage of Saskatchewan residents reporting excellent or good quality of hospital care is higher than the percentage for the whole Canadian population. Looking at males and females combined, the 65 plus age group had the highest percentage of people reporting excellent or good quality care in both Saskatchewan and the general Canadian population. In both Saskatchewan and in Canada, the 15 to 19 year old age group had the lowest percentage of people reporting excellent or good hospital care.

Overall, the approval rating for hospital services is not as high as the rating for health care services in general.

Persons 15+ yrs receiving hospital services in previous 12 months reporting excellent or good quality of health care received. Saskatchewan 2000-01



Source: Canadian Community Health Survey (sub sample approximately 25,000) – cycle 1.1 2000

CANCER SERVICES

The Saskatchewan Cancer Agency received more than $6.5 million in new funding in the 2001-02 health budget to strengthen care for patients. This funding increase brings the agency's overall budget to approximately $40.1 million – an increase of close to 20 per cent over last year's budget.

This funding increase helped the agency to continue providing cancer patients with quality treatment and timely access to care. Almost 47,000 cancer treatments are given annually to an average of 4,218 new patients at the Saskatoon and Regina Cancer Clinics.

While the Saskatchewan Cancer Agency strives to provide timeliness of access to cancer treatment in Saskatchewan, they have faced some challenges with the competition across North America for skilled staff.

The development of the Prevention Program for Cervical Cancer was formally announced in 2001-02. A steering committee, the Advisory Committee for the Prevention Program for Cervical Cancer, will design and implement an organized cervical cancer screening program for Saskatchewan. The program is expected to take two to three years to develop and will be fully operational in 2004. This is an important initiative in the fight against cancer, as cervical cancer is almost completely preventable with early screening.

The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven stationary sites around the province and one mobile mammography unit which travels to communities that are not served by a stationary site. The Screening Program has the highest participation rate in Canada, with more than 36,000 women screened annually.

Female Breast Cancer

The incidence rate of female breast cancer is becoming a recognized indicator of health status.

Saskatchewan's age-standardized female breast cancer incidence rate increased by 32 per cent from 1976 to 1997. A similar trend was reported at the national level. Although part of the increase may be related to early detection through breast self-examination, as well as increased mammography screening, the actual incidence of breast cancer is likely also rising. This may be due, in part, to changes in childbearing patterns. Women today are, on average, more likely to have their first child at a later age, and to have fewer or no children at all.

The most significant risk factors for developing breast cancer include age, family history of breast cancer, high levels of radiation exposure to the chest, obesity and various reproductive factors such as never having had children.

Age standardized female breast cancer incidence rate, Saskatchewan and Canada, 1976-1997

Source: CIHI, 2002 health indicators supplement to the Health Care in Canada report

Improving Quality and Accessibility

Among the provinces and territories, Saskatchewan had the fifth lowest age-standardized female breast cancer incidence rate, while the Northwest Territories had the highest.

Emergency Medical Services

Air Ambulance

Saskatchewan Air Ambulance continues to provide a high-quality critical care level inter-facility transfer service to the province. The program, known as Lifeguard, is administered by Saskatchewan Health and is based at the Saskatoon airport. The cost to an individual for air ambulance service is $350 per flight. The remaining costs are covered by Saskatchewan Health. The individual is also responsible for road ambulance fees for the transfer to and from the airport.

During the past fiscal year, the Government of Saskatchewan approved the acquisition of two new King Air B200 aircraft for Saskatchewan Air Ambulance. The first new aircraft came in to service in November 2001; the second one came in to service in March 2002.

The Saskatchewan Air Ambulance Service provided approximately 1,060 flights in 2001-02 to transport critically ill or injured patients who needed specialized care.

Road Ambulance

Saskatchewan has 113 road ambulance services. More than 3,100 people provide emergency medical services in the province. In 2001-02, licensed ambulance services responded to 82,769 calls.

Road ambulance services are not a directly insured benefit. However, the department does provide direct grants to health districts to help offset the cost of providing this service to the public. The balance of operating costs is covered through fees and charges established by individual health districts.

Saskatchewan Health has a program in place called the "Senior Citizens' Ambulance Assistance Program" (SCAAP) to reduce fees for senior citizens (age 65+). This program provides cost protection to seniors by limiting the cost of a road ambulance trip/call within the province to $250.

The number of claims handled in 2001-02 totalled more than 9,500.

Compensation Parity

In 2001-02, Saskatchewan Health provided $3.68 million to improve wages/benefits for employees of contracted ambulance services. This was in addition to $700,000 provided in 2000-01.

This funding helped to address disparities in compensation between the health district emergency medical services personnel who are covered by the Saskatchewan Association of Health Organizations/Health Sciences Association of Saskatchewan collective agreement and the non-unionized employees of contracted ambulance services. This wage disparity has created significant retention and recruitment issues for contracted ambulance services and the health districts they serve.

Services for Seniors

Seniors make up a large proportion of Saskatchewan's population. Currently one in seven (14.5%) or 148,032 people in the province (June 2001) are 65 years of age or older. Seniors are the most frequent users of the health system, and make up the largest part of people residing in special-care or personal care homes, or receiving home care services.

Special-Care Homes

Special-care homes, also known as "nursing homes", are funded by government through district health boards.

When a family member's care can no longer be met by family or through home care or other community-based options, placement in a special-care home is considered. Each individual is assessed and given priority for placement based on that assessed need. Districts offer the person with greatest need and at the greatest risk the first available bed, with the option to transfer to the facility of their choice when a bed becomes available there. Admissions to special-care homes are based on need.

Saskatchewan currently has 118 special-care home beds per 1,000 residents aged 75 plus. This is the second highest of all provinces and above the national average of 100 beds per 1,000 residents aged 75 and older.

Improving Quality and Accessibility

- **As of March 31, 2002 services were delivered by 158 licensed special-care homes and 32 hospital-based long-term care units to 8,748 residents. All these beds are publicly subsidized.**

Residents of special care homes pay an income tested resident charge that is based on annual income. Special care homes are heavily subsidized by government. On average, the resident charge represents approximately 23 per cent of the total cost of an individual's care and accommodation. The resident also pays for medication and for personal supplies.

In Saskatchewan the long term care system includes both long term accommodation and shorter term respite services. Respite services provide relief for family members who are caring for a loved one at home or in a community setting.

- In 2001-02, there were 1,186 participants in adult day programs across the province.

- A total of 3,250 individuals received respite care in special care homes, hospitals and health centres across the province in 2001-02.

Minimum Data Set

One of the key initiatives this year for long term care is the continued implementation of the Minimum Data Set (MDS). This is a new type of assessment and information system that assesses residents in long term care facilities. It helps improve client care by supporting better care planning, quality indicators, (e.g., how many falls did the facility have) and outcome measurements which could result in changes to programs or service. The majority of all special care homes in the province are now using MDS, with the rest to follow within the next year. This new system also allows comparisons with other facilities, health districts, provinces, or even other countries.

Personal Care Homes

Personal care homes are privately owned and operated facilities that offer accommodation and meals, supervision and personal care support to people who generally do not need the level of care provided in publicly subsidized special care homes.

Residents of personal care homes do not have to demonstrate their need to be admitted. They are there because they choose to be, or because they feel they want the level of service provided. However, they pay the full cost of their care.

As of March 31, 2002, there were 275 licensed personal care homes in 27 of the 32 health districts in Saskatchewan, with the ability to care for 2,498 residents.

Personal care homes can accommodate up to 40 residents. As a result of the government's health plan, this limit will be eliminated. This will allow the development of larger personal care homes, giving seniors and people with disabilities more options to remain independent.

Saskatchewan Health will be expanding regulatory monitoring to ensure quality care in larger homes. Amendments to the personal care home regulations and standards to accommodate the removal of the 40 bed limit will be completed during 2002, following consultation with stakeholders.

Home Care

Most people who are sick or need some level of support would prefer to stay in their own homes. The purpose of home care in Saskatchewan is to help people who need acute, palliative and supportive care to remain independent. Home care services can range from housekeeping or personal care to daily meals, nursing care, respite care, and training and support of family members who help provide care. Admittance to the home care program is based on assessed need and the risk to the individual if support is not provided.

While there is no charge for nursing care, assessment and care co-ordination, and professional therapy services, clients pay a fee for other services. The chargeable items include services like homemaking and meals. This fee is based on income and will vary for each individual. Overall, government covers more than 92 per cent of the cost of delivering home care across the province.

- In the last ten years, provincial funding for home care programming increased from approximately $32.6 million to $86.5 million.

- Client fees amount to less than eight per cent of the total cost of the service.

Mental Health Services

Mental health services are available in all health districts in more than 100 different centres in Saskatchewan, serving approximately 25,000 clients each year with both inpatient and outpatient care.

In 2000-01, a total of 5,107 patients were discharged from inpatient mental health units of hospitals across the province. The average length of stay was 14.81 days, continuing a downward trend in this statistic.

Saskatchewan Hospital North Battleford (SHNB) is the province's only facility dedicated specifically to intensive rehabilitation of people with serious and persistent mental illness. SHNB is managed by the Battlefords Health District but serves the entire province.

The mandate of the hospital is to provide longer-term rehabilitation for people with mental illness whose needs cannot be met in local inpatient mental health facilities. In addition to psychiatric rehabilitation, SHNB also provides a 25 bed forensic unit for remand assessment, treatment, and special disposition under the Criminal Code for persons found "Not Criminally Responsible." In total, SHNB has 178 beds.

High-Risk Youth

Saskatchewan Health recognizes that the mental health needs of youth must be a priority. In 2001-02, a number of creative programs focusing on the mental health needs of children and youth in the province were introduced across the province. A good example is the *Healing Hurting Hearts Bereavement Camp*, located in Prince Albert.

This camp is intended to assist children and youth in the process of healthy grieving by bringing them together in a supportive, therapeutic, retreat style environment. The partners in this initiative include the Prince Albert and District Palliative Care Association and Prince Albert Mental Health. This program is open to boys and girls 7 to 15 years of age who have experienced the death of a parent, sibling, or other loved one. During their time together, these young people have the opportunity to meet and make friends, while they learn about the process of bereavement. The camp was offered for the first time in November 2001.

Acquired Brain Injury

Each year nearly 2,200 people in Saskatchewan suffer a brain injury. Falls by children and the elderly, and motor vehicle crashes are the leading causes of brain injury. These kinds of injuries can have devastating long-term consequences for the victims and their families.

Saskatchewan Health and Saskatchewan Government Insurance (SGI) established a unique partnership to create an enriched level of community-based services for people with an acquired brain injury (ABI), and for their families.

These services and programs enable clients, families, and caregivers to receive education, rehabilitation, life enrichment, residential, and vocational services as close to their home communities as possible. There are currently 37 programs and three outreach teams being funded under the ABI Partnership Project.

- Overall, the ABI Partnership Project provided direct services and programs to more than 1,200 survivors and their families in the year 2001-02.

- The project also reached in excess of 30,000 participants through its education and prevention programs like Brain Walk and playground and bicycle safety.

Each year in Canada, 34,000 people are admitted to hospital with brain injuries. In Saskatchewan, approximately 2,200 people suffer a brain injury each year.

Alcohol and Drug Services

Rehabilitation and Recovery Programs

Saskatchewan Health, through its funding to health districts and community-based organizations, provides a full range of recovery services to meet the needs of residents affected by alcohol and drug abuse. These include

outpatient counselling, inpatient rehabilitation, detoxification, day patient and long-term residential programs.

- In 2001-02, Saskatchewan Health funded 260 alcohol and drug services inpatient beds in the province. A total of 47 outpatient facilities for youth and adults were available throughout the province.

Hepatitis C, HIV and Blood-Borne Infections

Saskatchewan Health is taking an active role in helping to reduce the rates of Hepatitis C, HIV and blood-borne infections and other harms associated with injection drug use. Steps taken in 2001-02 include:

- assisting with the development of three new needle exchange pilot programs in Moose Jaw, North Battleford and Ile-a-la-Crosse;
- enhancing funding for existing needle exchange programs in Prince Albert, Saskatoon and Regina; and
- working in partnership with the College of Physicians and Surgeons of Saskatchewan to develop, implement and monitor guidelines for physicians to deliver uniform, community-based methadone programs in Saskatchewan.

Fetal Alcohol Syndrome

The prevention and treatment of Fetal Alcohol Syndrome (FAS) continues to be a priority for Saskatchewan Health. FAS is a life-long disability caused by a mother's drinking alcohol during pregnancy. A number of new initiatives and partnerships were established in 2001-02 including:

- Saskatchewan Health was the lead jurisdiction for the Prairie Northern FAS Partnership. A sold-out conference was held in May 2001 with more than 600 people attending from across North America to look at issues and challenges of FAS faced by youth, families and communities.
- A new provincial FAS Awareness Poster was developed in partnership with Saskatchewan Health, Saskatchewan Liquor and Gaming Authority and Saskatchewan Institute on Prevention of Handicaps.
- Funding was provided to Saskatchewan Institute on Prevention of Handicaps to develop FAS public service announcements for television and radio.

District Quality of Care Co-ordinators

The Canadian Community Health Survey showed a high percentage of Saskatchewan residents reported excellent or good quality health services. (see page 25). However, if a client has concerns about any care they received they can share them with their health care provider or an appropriate supervisor. If further assistance is needed, those concerns can be taken to a District Quality of Care Co-ordinator.

All health districts receive funding for a District Quality of Care Co-ordinator (DQCC) or designate. The role of the DQCC is to:

- Assist individuals and families with questions or concerns about health services in their district;
- Ensure individuals are informed about their rights and options; and
- Recommend improvements to enhance the quality of health services delivered in the district based on their findings and trends of concerns raised.

The DQCC role is part of a comprehensive approach to ensure the best possible quality of services. The co-ordinator keeps track of all client concerns in a specialized database. This information is valuable to districts, as it helps them to identify opportunities for improvement and therefore enhance the quality of care.

Districts are required to report a standardized summary of their client concern information (with any identifying and case specific information removed) to the department annually.

Client Concerns Registered with District Quality of Care Co-ordinators

	1997-98	1998-99	1999-00	2000-01
Number of Clients who reported concern	1705	2026	1787	1810

The number of clients who reported a concern during the previous four years has remained relatively stable. Of the total number of people who had some form of contact with the health care system in 2000-01, less than one per cent lodged a concern with a DQCC. This may not reflect the total number of concerns in the system, however, as clients and their family or friends may not be aware that a formal mechanism exists to record and respond to their issues.

In addition to tracking the volume and nature of concerns, DQCCs also record how quickly each concern was resolved. A concern is considered resolved from the district's perspective when the DQCC, either orally or in writing, provides a response regarding the issue raised. The majority of the 1,810 concerns received in 2000-01 were resolved in a timely manner.

- In 2000-01, 82 per cent of the total client contacts were resolved within 30 days of receipt, down from 83 per cent in 1990-2000.

Reasons for cases taking longer to resolve may include delays when referring a question or issue to a health care professional for more information, and/or repeated consultations with the client or family.

As a performance indicator, the DQCC information is one method of tracking the type and volume of health care concerns across the province. As Saskatchewan Health and districts continue to promote the role of the DQCC it is anticipated that the number of contacts may increase.

Telehealth Services

With a large portion of Saskatchewan's population living in rural or northern areas of the province, the development of "telehealth" services continues to be a priority for Saskatchewan Health. Telehealth allows residents in remote areas access to important health information, specialists, family physicians and other health providers located in larger centres.

Currently, *Telehealth Saskatchewan* operates in nine, mostly northern communities, but future expansion to support the network of northern, district, regional and provincial hospitals is outlined in the government's health plan.

On August 3, 2001, Provincial Health Minister John Nilson and Federal Health Minister Alan Rock announced a joint commitment of $2.7 million over a two-year period to upgrade and expand Saskatchewan's telehealth network. New sites will be added to the network in the near future, beginning with Regina, to help "anchor" clinical services in the south and support medical resident training programs in Regina.

A Strong Workforce

Every health care system relies on key health providers to deliver the services that people need. When vital health care workers are in short supply, this can make the delivery of health care services more difficult.

In some cases health districts have had to cut back on services because of difficulty in recruiting nurses, physicians and other key personnel. Some health employers report that it is hard to fill these vacancies because of a lack of full-time positions, shortages of qualified candidates, geographical remoteness and barriers in collective agreements. This situation is not unique to Saskatchewan. Jurisdictions across North America face similar hurdles.

The human resource challenges within the health system call for a variety of solutions. Some require a change in the way we deliver health care. Others relate to training, keeping and attracting skilled people to provide the services that we need.

PHYSICIANS

College of Medicine

Saskatchewan Health supports educational activities at the College of Medicine through the Clinical Services Fund. With a budget of $20.6 million in 2001-02, the Clinical Services Fund covered areas such as:

- academic and clinical services provided by faculty;
- undergraduate, post-graduate and continuing medical education; and,
- post-graduate medical resident salaries and benefits.

In September 2001, the number of undergraduate seats in the College of Medicine was expanded from 55 to 60. The expansion will provide an opportunity to train more physicians and return medical school enrollment to the 1994 level of 60 positions. A sustainable, incremental approach to increasing enrollment is one part of an overall strategy to increase the supply of physicians in Saskatchewan.

The Saskatchewan Academic Health Sciences Network (SAHSN) was launched in January 2002 in order to foster partnerships in clinical service, research and teaching. It is comprised of health regions, government (the Departments of Health and Learning), and the health sciences programs at the University of Saskatchewan. Historically, approximately 65 per cent of the College of Medicine's annual budget originates from the departments of Health and Learning.

In 2001-02, approximately 70 per cent of the graduates of the Family Medicine Program at the University of Saskatchewan remained in our province. This is a significant increase from the retention rate of just 40 per cent about four years ago. Some of the initiatives to encourage medical graduates to remain in Saskatchewan include:

Undergraduate and Resident Bursaries
Currently, 6 medical residents and 15 undergraduate medical students are receiving bursary funding. These are given for a return service commitment. In 2001, the value of the undergraduate bursary increased from $18,000 to $25,000 per year. To date, 101 bursaries have been awarded.

Rural Practice Establishment Grant (RPEG)
This program makes grants of $18,000 available to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months. Since its inception in 1997, 38 physicians (23 foreign-trained and 15 Canadian-trained) have taken advantage of the program, locating in communities such as Meadow Lake, Kindersley, Humboldt, Nipawin and Assiniboia.

Rural Practice Establishment Training (RPET)
This program provides income replacement for in-practice rural physicians, and assistance to medical residents wishing to take specialized training in an area of demand in rural Saskatchewan. There is currently one applicant in the program. In-service rural physicians and second-year family medicine residents are eligible for funding to enhance their skills in obstetrics, anaesthesia, general surgery, psychiatry, emergency medicine or geriatrics.

A Strong Workforce

Re-entry Training Program
Three applicants were enrolled in the program in 2001-02. The purpose of the program is to support family physicians who wish to become specialists in areas that have been identified as being in need.

Specialist Emergency Coverage Program
The Specialist Emergency Coverage Program was implemented in July 2001 to compensate specialists for being available (on-call) to provide emergency medical services for new or unassigned patients. This program is a collaborative effort and is jointly administered by health districts, Saskatchewan Health, and the Saskatchewan Medical Association. The program supports more than 150 specialist call rotations in 13 communities.

Physicians in Saskatchewan

The overall number of physicians in Saskatchewan has been gradually increasing over the past few years. At the end of March 1998 there were 1,528 physicians in the province. By March 31, 2002 that number had risen to 1,622.

Licensed* Physicians	Mar. 98	Mar. 99	Mar. 00	Mar. 01	Mar. 02
General Practitioners	857	895	924	909	897
Specialists	671	692	702	712	725
Total	1,528	1,587	1,626	1,622	1,622

* The number of licensed physicians includes temporary licensed "locum" physicians, excludes medical residents and house officers in hospitals, and allocates non-(Canadian) certified specialists to the specialist category.

While the number of physicians in Saskatchewan has increased slightly over the past few years, many rural and northern areas still face extreme challenges in attracting and keeping doctors. Eighty per cent of the physicians in Saskatchewan practice in urban areas, with the remaining 20 per cent located in rural practices.

The province continues to rely on recruitment of foreign-trained physicians. At March 31, 2001, approximately 62 per cent of general practitioners in the province were foreign-trained, 33 per cent were graduates from Saskatchewan, and 5 per cent were from other Canadian provinces. However, a larger percentage of specialists are trained here at home. Saskatchewan graduates represent approximately 37 per cent of the total number of specialists practising in the province, while foreign-trained and other Canadian graduates make up 45 per cent and 18 per cent respectively.

Physician Remuneration

The predominant method of payment for physician services in Saskatchewan is the fee-for-service system. Payment is established by agreement between the province and the Saskatchewan Medical Association, based on rates outlined in the Physician Payment Schedule. In 2001-02, fee-for-service payments for Saskatchewan physicians totalled about $280 million.

Non-Fee-For-Service Compensation –
Some Saskatchewan physicians derive the majority of their income from mechanisms other than fee-for-service. Non-fee-for-service funding arrangements for physician services represent a large and growing area of provincial health expenditures. In 2001-02, this sector accounted for more than $100 million, or 25 per cent, of Saskatchewan Health's total expenditures on in-province physician services. The majority of these expenditures were in areas of medical services associated with health district operations (radiology, laboratory, and emergency services).

District medical remuneration has been identified as an area of increasing prominence and cost pressures for provider groups. In 2001, Saskatchewan Health established a new Medical Remuneration Unit to assist health districts and other stakeholders in addressing emerging issues in this program area.

Alternate Payments -
Alternate payments provide different ways of reimbursing physicians for clinical services, other than the traditional fee-for-service system. These arrangements have been identified as enhancing opportunities to work as part of an integrated health team, and may provide positive effects on physicians' lifestyles and the predictability of their

income. Expenditures on alternate payment projects increased to $13.9 million in 2001-02, up from $12.4 million in 2000-01. Another $2.7 million was spent on other initiatives, such as a neurosurgery agreement with the College of Medicine and funding for family practitioners in the Department of Family Medicine at the college

Both general practitioners and specialists have taken advantage of opportunities for alternate payment arrangements. General practitioners receiving alternate payments work in practices in rural, regional and larger urban centres. Specialists are remunerated through alternate payments in Regina, Saskatoon and several regional centres in specialties such as intensive care, general surgery, obstetrics and gynecology, anaesthesia and pediatrics.

NURSES AND OTHER HEALTH PROVIDERS

While ensuring a good supply of physicians in our province is critical, keeping and attracting other key health providers such as nurses continues to be a top priority for Saskatchewan Health. The Action Plan for Saskatchewan Health Care outlined a specific human resources plan for these health care providers which includes the following key initiatives:

- Train more health care providers in Saskatchewan;
- Develop a representative workforce;
- Target bursaries to fill vacancies;
- Expand continuing education and development;
- Improve job satisfaction;
- Implement province-wide health human resource planning; and
- Maintain a commitment to health sciences education and research.

By the Numbers - Our Health Workforce

Tracking the actual number of people who work within the health professions can be difficult, as people move, and change jobs, hours of work, or even careers.

One way to measure our health workforce is to count how many providers are registered in the province. The Canadian Institute for Health Information (CIHI) does this every year, based on registration numbers from professional associations like the Saskatchewan Registered Nurses Association (SRNA). The data allows comparisons with other provinces.

According to the Canadian Institute for Health Information report – *Supply and Distribution of Registered Nurses in Canada, 2001*, the number of RNs per capita in Saskatchewan in 2001 was higher than the Canadian average, but decreased from 1997.

- **The number of RNs per capita in Saskatchewan in 2001 (80.8 per 10,000 population) is higher than the Canadian average (74.3 per 10,000 population).**

The number of RNs in Canada decreased from 259,758 to 252,913 in 2001, a decline of 2.6 per cent. However, overall in Canada the number of RNs *employed* increased slightly during that time by 1.2 per cent.

The ratios of RNs per 10,000 population for all provinces and territories are summarized in the chart below.

Ratios of RNs per 10,000

SK	BC	AB	MB	ON	PQ	NF	PEI	NS	NB	YT	NWT	Nun	CA
80.8	66.7	74.5	89.3	67.6	79.6	102.0	91.4	99.7	97.6	91.9	116.1	100.9	74.3

Source: Canadian Institute for Health Information – Supply and Distribution of Registered Nurses in Canada, 2001

A Strong Workforce

While Saskatchewan is near the midpoint of the provinces for its number of RNs per capita, the CIHI report also identified trends that indicate we need to continue efforts at retaining and recruiting nurses.

For instance, the average age of a registered nurse in Saskatchewan is going up. In 2001, the average age of a Saskatchewan RN was 44.1, higher than the Canadian average. Only British Columbia and Ontario had higher averages, with 44.8 and 44.3 respectively.

Saskatchewan Health recognizes that an ageing workforce means increasing numbers of nurses will be eligible for retirement. This underscores the importance of future retention and recruitment initiatives.

There are signs of progress, however, that show nursing graduates are more enthusiastic about remaining in Saskatchewan. Over the past couple of years, our province has been able to retain about 80 per cent of graduates coming out of the nursing education program.

Aside from nurses and physicians, there is a wide range of other health care professionals who are also vital to the provision of quality care. Registration data for these professionals — including technologists, therapists and pharmacists — are available from the various regulatory organizations. As the table shows, the number of these professionals working in Saskatchewan has for the most part increased over the past decade.

Profession	1990	1999	2000	2001
Speech Language Pathologists/ Audiologists	107	220	207	219
Physical Therapists	304	504	521	524
Pharmacists	909	1087	1108	1129
Occupational Therapists	95	192	201	199
Medical Radiation Technologists	394	440	426	425
Medical Lab Technologists	1025	958	963	945

Source: Regulatory Organizations

KEEPING AND ATTRACTING HEALTH CARE PROVIDERS

Keeping and attracting health providers are top priorities for government. Steps are being taken to ensure a good supply of health professionals:

Re-entry Bursaries -
In April 2000, a bursary program was established for nurses who wish to re-enter their respective professions. The program applies to previously licensed Registered Nurses, Practical Nurses and Registered Psychiatric Nurses. By spring 2002, 124 bursaries had been awarded, 73 for RNs, 39 for LPNs, and 12 for RPNs. These return-service bursaries cover 60 per cent of tuition costs in the Nursing Re-entry Program.

Health Bursaries -
Financial compensation is offered in return for a commitment to work in the related health field within Saskatchewan for an agreed-upon length of time. In 2001, 27 bursaries were offered to students in the following categories: physical therapists (PTs) – 7; occupational therapists (OTs) – 5; respiratory therapists – 4; audiologists – 2; public health inspectors – 3, speech language pathologists – 5; and psychologists - 1.

Recruitment Activities -
Saskatchewan Health continues to contract Lifestream Development Services to co-ordinate recruitment activities on its behalf, not only for physicians, but for a wide range of health professionals from nurses to occupational therapists. Lifestream attended recruitment fairs in Edmonton and Victoria last year, and organized seven career days in Saskatoon and Regina.

Adopt a Student Program -
26 second-year nursing students, 58 first-year medical students and 20 first-year physical therapy students participated in the adopt-a-student program with health district employers during 2001-02.

A Strong Workforce

Sonographer -
It costs between $35,000 and $40,000 to train one ultra-sound technician because they must leave the province for their schooling. In order to build and stabilize a small sonography workforce, Saskatchewan Health and the health districts funded the training of five sonographers in 2002. Each of the five students who receive funding for sonography training will be committed to working in Saskatchewan upon graduation.

Inter-provincial collaboration -
Saskatchewan Health is working with Alberta Learning and with SAIT (Southern Alberta Institute of Technology) in Calgary to increase the number of Saskatchewan students being trained as respiratory therapists and nuclear medicine technicians via interprovincial training agreements. The first enrollment of Saskatchewan students in Saskatchewan purchased seats occurred in fall 2001. As well, the province continues to purchase three OT seats at the University of Manitoba and ten OT seats at the University of Alberta. The number of seats at the University of Alberta will increase to 15 over the next three years.

- **The number of Speech Language Therapists and Physical Therapists (PTs) has increased significantly during the past ten years.**

- **Market Supplement Program** - SAHO, in conjunction with health sector unions, has developed a province-wide market supplement program. The Provincial Market Supplement Program is designed to address specific pay related skill shortages by use of a temporary market supplement to attract and/or retain qualified employees.

- **EMT Training Initiative** - *The Action Plan for Saskatchewan Health Care* outlined a goal of training 240 new or existing EMS providers to the EMT-Basic level, over a three-year period. Once a sufficient number of EMTs are trained the Department can adopt a standard requiring at least one EMT on every ambulance call provided in the province. The first priority for EMT training will be in health districts where a significant proportion of ambulance calls have Emergency Medical Responders (EMRs) as the highest-trained providers

A Representative Workforce
Saskatchewan Health recognizes that while First Nations and Metis people make up a significant proportion of our population, they are under represented within the health workforce. The government has initiated a number of program changes and incentives to encourage more Aboriginal people to enter health professions. They include:

- Saskatchewan Health provided $37,500 in 2001-2002 to enhance the Native Access in Nursing Program (NAPN) at SIAST. The funding will allow SIAST to hire one Aboriginal Educator to work with Aboriginal nursing students in the *Nursing Education Program of Saskatchewan* (NEPS) and Practical Nursing Program.

- In June 2001, Saskatchewan Post-Secondary Education and Skills Training and Saskatchewan Health announced the establishment of a new 40-seat pre-health professions program to be situated in Prince Albert. This one-year training program, which began in fall 2001, will academically prepare aboriginal and northern students for careers in nursing and other health sciences programs. Beginning in 2002-2003, a northern nursing program for aboriginal students will be developed as an extension of the existing NEPS.

- Saskatchewan Indian Federated College (SIFC) has established a degree program in Environmental Health and Science. Approximately five students will be eligible to write a national exam to qualify them as public health inspectors in 2002.

- The Dumont Technical Institute funds seats in the Practical Nursing Program in the North and has offered the program for aboriginal students at Meadow Lake, LaRonge and Creighton. Students gain practical experience in the northern health districts.

- Saskatchewan Health, in partnership with the northern districts (North East, Mamawetan Churchill River, Keewatin Yatthé), and Athabasca Health Authority, provides funding for an Aboriginal Summer Student Program. The districts offer summer employment to youth who are interested in pursuing careers in the health sector.

A Strong Workforce

While incentives to draw First Nations and Metis people into health careers are starting to show promise, Saskatchewan Health has also played a role in assuring those new health professionals are given employment opportunities. There are currently 22 partnership agreements with health employers who have hired approximately 1,200 aboriginal people. This will continue to be a high priority.

Job Satisfaction

Once individuals have selected a career in the health sector, job satisfaction can play a large role in how long they remain in their chosen field. Saskatchewan Health has taken steps to enhance workplaces to improve contentment of those in the workforce. Some of the pilot projects include:

- Magnet Work Environment - $400,000 was provided to the Moose Jaw-Thunder Creek Health District to support the research into the development of a "Magnet" work environment, in cooperation with the SRNA. As well as the pilot project at Moose Jaw Union Hospital, two sites have been added - a unit of Parkridge Centre in Saskatoon and the integrated care facility at Unity. After an assessment of these workplaces is completed, a working group composed of staff and management will identify potential workplace improvements at each site.

- Casual Workforce - The Regina Health District was provided with $150,000 in April 2001 to research and develop strategies to address the impact of a significant casual workforce upon the workplace. Analysis of sick time usage, hiring practices and overtime costs were included in the review.

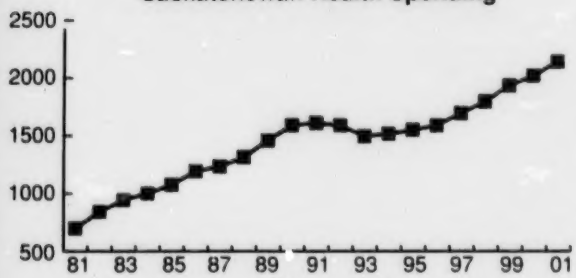
- Senior Nurse Mentors - Saskatoon District Health was provided with $150,000 in April 2001 to assist in the development of a workshop and protocols for senior nurses who mentor nursing students receiving clinical experience. This project involves a workshop for senior nurses, workload relief for the nurses while they are working with students, and an appropriate recognition program.

Efficiency and Accountability

While we all want accessible, quality health care, we also need to be able to pay for it. Providing health care services is enormously expensive, and the costs go up every year. Since 1995-96, government spending on health care in Saskatchewan has gone up by about 37 per cent. The 2001-02 health budget of more than $2 billion amounted to almost 40 per cent of all provincial spending on programs and services.

Health care spending has increased dramatically over the years. Pressures on the health budget include inflation, rising wages, fees and population shifts. Further cost pressures are caused by the expansion of medical knowledge, and the resulting new technologies, new treatments and new drugs.

Saskatchewan Health Spending



Saskatchewan Health continues to work towards creative solutions for many challenging health delivery issues, while ensuring the best value for our health care dollars.

Instead of simply spending more, we need to spend more wisely. *The Action Plan for Saskatchewan Health Care* contains a number of measures aimed at more effective health spending, such as the *Quality Council* and amalgamation of health districts.

Regional Health Authorities

The Action Plan for Saskatchewan Health Care announced the merging of 32 health districts into 12 Regional Health Authorities (RHAs).

Combining the 32 districts into 12 will help reduce duplication and lead to more efficient management. It will also bring together a critical mass of the skills needed to plan and deliver health services. Larger Regional Health Authorities will be better able to recruit health care providers, and will have the capacity to offer a full range of primary health care services.

Advantages of new, larger Regional Health Authorities:

- **reduced duplication, more efficient administration;**
- **wider range of services in each region;**
- **ability to recruit and retain health care providers and management teams;**
- **improved planning and co-ordination among regions; and**
- **local involvement through Community Advisory Networks.**

To plan a smooth transition to the new system, government established RHA boards as planning committees, until the new health authorities were officially created through legislation.

In February 2002, Health Minister John Nilson appointed 120 people to sit on the planning committees of the soon-to-be created Regional Health Authorities (RHAs). The appointees were chosen from nearly 500 applicants who had declared their interest in representing the people of their areas.

In early March 2002, the process was begun to accept declarations of interest for the two northern Regional Health Authority boards. The Athabasca Health Authority in the far north of the province will not be affected by the new legislation because of its unique relationship with the federal government, the province and its residents. The legislation will permit all health regions to maintain close ties with residents by creating Community Advisory Networks that will ensure local involvement in board decisions.

A map showing the boundaries of the new Regional Health Authorities can be found in Appendix III of this annual report.

Quality Council

The Quality Council, reporting to the Minister of Health, will be the first organization of its kind in Canada with a mandate to improve the quality of

health care. The council will be an independent, knowledgeable voice that will provide objective, timely, evidence-based information and advice for achieving the best possible health care within available resources.

The role of the Council is to provide advice to government, Regional Health Authorities, health professionals, stakeholders and the general public on ways to improve the health system's quality and safety.

Work is underway to establish the Council as soon as possible.

Cost of Health Services

Government funding to our health system amounts to about $2.2 billion dollars each year. This funding supports a wide range of health services across the province. Because many of those services are fully or partially insured by the health system, people do not have a clear idea of the actual cost of their care. Here are some approximate costs as of March 31, 2002, including both the government's share and the patient's share (where applicable), for some of these services:

- Estimated average cost of a basic visit to a hospital emergency department - $90.
- Routine office visit to a family physician (excluding tests, cost varies depending on the age of the patient) - $22.50.
- Cataract surgery (day surgery) - $1,400.
- Hip replacement (in-patient surgery) - $8,900.
- Cost of vaccines to complete routine immunization of one child (birth to age 16) - $170.
- Estimated cost of a typical childbirth in hospital (including pre-natal physician care) - $3,420.
- Average cost of post-natal home visit by a public health nurse - $55.
- Average annual cost of operating one hospital bed - $159,000.
- Average annual cost of one nursing home bed - $51,000.
- Average annual cost of providing home care to one person - $3,400.

Saskatchewan Drug Plan

Prescription drug costs are one of the fastest-growing portions of our health budget. In 2001-02, Saskatchewan residents filled 7,979,826 prescriptions, bringing the total drug plan expenditure to $116.8 million. This includes drug plan payments of $114.9 million to help cover the cost of prescriptions for residents, as well as transfers to health districts of $1.9 million.

New drugs on the market were carefully considered for potential coverage by two review panels. From April 2001 to March 2002, 210 drug products were recommended for either full coverage or *Exception Drug Status* (EDS) coverage under the drug plan. In this same period, 18 drug products were not recommended for coverage. Decisions on whether to provide coverage are based on a drug's cost effectiveness and medical effectiveness.

Saskatchewan Prescription Drug Plan

	1997-98	1998-99	1999-00	2000-01	2001-02
# of drugs covered	3,112	3,366	3,544	3,589	3,491
# of prescriptions processed	6,216,167	6,622,455	7,014,580	7,534,148	7,979,826
# of prescriptions/beneficiary	10.1	10.5	11.1	11.9	12.7
# of families receiving benefits	88,277	103,564	106,848	111,591	114,710
Average cost per prescription	$27.34	$28.53	$29.22	$30.86	$32.76
Drug Plan payments	$65.2M	$76.0M	$85.4M	$99.1M	$114.9M

Efficiency and Accountability

As of March 2002, the Prescription Drug Plan provided coverage for approximately 3500 drug products. This is lower than last year, as some manufacturers have discontinued production of certain products that were listed in the Formulary. In most cases, other brands or strengths continue to be listed.

The Family Health Benefits program assists lower income families with the costs of raising healthy children. It is part of the Government of Saskatchewan's Building Independence initiative. The benefits covered include drugs, medical supplies and appliances, dental and optical services, and ambulance services for children under 18 years.

Sustaining Public Medicare

With the release of *The Action Plan for Saskatchewan Health Care*, government reaffirmed its unwavering commitment to publicly funded, publicly administered medicare as the fairest and most cost effective way of delivering health care.

The Action Plan will address immediate needs in the health system, while providing a long-term vision to guide future decisions and investments. In addition to improving quality and access, government is striving to make the system more sustainable into the future, through the following:

- making the best possible use of the skills of all health providers;
- using effective primary health care services to help prevent illness or control conditions before they become more serious and require more expensive treatments;
- reducing duplication in administration and improving co-ordination and planning by replacing 32 health districts with 12 Regional Health Authorities;
- creating more efficient delivery of hospital services and eliminating duplication through the clear classification of hospitals; and
- working with the federal government to ensure adequate funding of Medicare.

Health Spending in Saskatchewan

Given the growing cost of health care, rapidly emerging technologies and growing demands, it is more important than ever to ensure we are getting the best value possible for our health dollars.

This section provides a thumbnail sketch of health care spending in Saskatchewan, and the measures taken to ensure financial accountability to the people of the province. It also provides Financial Statements for Saskatchewan Health for 2001-02 and summary Financial Statements for the province's 32 district health boards.

Saskatchewan Funding Versus Other Provinces

In 2001-02, our province spent approximately $2.2 billion on health care, or about $2,150 for every person in the province. This figure includes provincial government spending only; it does not include dollars from private sources such as individuals, or dollars spent by the federal government for direct health services for residents it is responsible for (e.g. Veterans, military personnel and First Nations people).

This is close to the national average, which is forecast to be $2,190 per person. Relative to other individual provinces, Saskatchewan ranks in the middle of the pack. It is important to note that the range in health spending between provinces is fairly narrow. Typically, small changes on a year-over-year basis can significantly shift a province's ranking relative to other provinces.

Discussion and Analysis:

Compared to five years ago, provincial health spending in Saskatchewan has grown by 37 per cent. This is well above our rate of economic growth. This is contributing to concerns about the long-term sustainability of health care costs. Health spending as a percentage of overall program expenditure has also risen compared to five years ago. This indicates that health expenditures are growing faster than government spending on other services.

There are many factors behind the steadily rising costs of health care. In addition to overall inflation, costs go up due to rising wages, a growing per capita use of services (e.g. tests, prescriptions), and population shifts. Alongside these trends, the expansion of medical knowledge itself—bringing with it new technologies, new treatments and new drugs—creates cost pressures. The table on the following page shows provincial funding for various parts of the health system, including the growth in each area.

Over the past five years, the greatest percentage increase in spending has been on provincial health services. This is largely a product of the increases in funding provided to the Saskatchewan Cancer Agency and the Canadian Blood Services. As an example, the additional funding to the Cancer Agency has helped cover the growing costs of cancer treatment (e.g. drugs, equipment, staffing), the rising number of cancer cases, and the growing number of patients living longer with cancer.

The five-year growth in the Drug Plan has also been high, relative to the overall spending increase on health care. This reflects the trend across the country. The number of prescriptions issued, and filled, goes up every year. In addition, the cost of each prescription has been growing, and a number of new, very expensive drugs have been added to the Formulary in recent years.

	Saskatchewan Health Spending					
Year ending March 31	1997	1998	1999	2000	2001*	2002
Health spending ($millions)	1,608.0	1,677.2	1,774.6	1,955.7	2,075.6	2,199.8
% of provincial health spending	37.4	38.4	36.7	38.5	39.5	38.4

* includes $49.8 million from Health Transition Fund

Health Spending in Saskatchewan

Health Programs	2001-02 ($000)	Increase 1 year (%)	Increase 5 year (%)
Acute care, rehabilitation & emergency response	820,446	8%	39%
Long term care	326,284	1%	30%
Home-based & community care	215,623	6%	23%
Provincial health services (Prov. Lab, health research, SHIN, immunization, Cancer Agency, Canadian Blood Services)	126,177	20%	131%
Physician services, medical education & medical services (chiropractic, optometric, dental out-of-province)	482,602	7%	35%
Prescription drug plan & other special assistance programs (family health benefits, SAIL, supplementary health, HIV assistance)	159,072	13%	69%
Capital & other	69,549	65%	-16%
Total	2,199,753	6%	37%

Hospital services remain the most costly part of our health system. The clear classification of hospitals and the development of hospital networks as outlined in the province's health plan will mean more efficient delivery of hospital services. All hospitals will have a defined level of services, allowing each to concentrate on what it does best. Duplication of services will be reduced, as hospitals share resources and work together to provide services.

The only area of spending that has decreased over the five-year period is "Capital and Other." This reflects a reduction in spending on the construction of health facilities.

Financial Accountability Statement

From a fiscal accountability perspective, the most significant risks and challenges to be managed by Saskatchewan Health include ensuring:

- Available funding goes to the highest priority health needs;
- Value is obtained for the money provided;
- Compliance with existing legislation and regulations;
- Proper controls are in place to safeguard public assets; and
- Appropriate results are reported to the public, the legislature and our partners in the health system.

There are a number of checks and balances in place to ensure these responsibilities are met. They include:

Audited Results – The Provincial Auditor's Office has legislative responsibility to audit Saskatchewan Health and to publish the results.

Accountable to Legislature - Saskatchewan Health, like all government departments, is required to appear before the Public Accounts Committee of the Legislature. In addition, the annual health budget is published in the Budget Estimates. Other health spending is detailed in the Public Accounts, and the Minister of Health appears before the Legislature's Committee of Finance.

Public reporting – The Annual Report is one of many documents published yearly by the department. Such publications help to establish the provincial accountability framework.

Comparative reporting – In September 2000, all provinces made a commitment to the Federal Government to develop annual public reports on the performance of their health systems. These performance measures will ensure comparative reporting and should help Saskatchewan people measure the effectiveness of their health system relative to other provinces. The first of these reports will be released in September 2002.

Holding third-party agencies accountable – Many of the health services that Saskatchewan people rely on are delivered by third parties such as health districts. As a result, measures must be in place to ensure accountability for government funding directed to these agencies. Saskatchewan Health uses service agreements, audited financial statements and required reporting of results from

these agencies to meet this responsibility. These measures help to ensure the appropriate and effective use of health dollars and provide accountability to the people of Saskatchewan.

Saskatchewan Health believes that these measures adequately ensure the appropriate and effective use of health dollars and provide accountability to the people of Saskatchewan.

Financial Reporting

This annual report presents the Financial Statements of Saskatchewan Health for the 12 months ending March 31, 2002. The Financial Statements report on the funding provided to the department through the government's General Revenue Fund.

This report also contains a summary of the Financial Statements of the province's 32 district health boards. The Financial Statements of these health districts are consolidated into the Summary Financial Statements of government. Each health district is responsible for providing its own annual report that documents how it used the funding received.

Saskatchewan Health is also legislatively responsible for the following agencies:

- Uranium City Hospital;
- Health Services Utilization and Research Commission (HSURC);
- Saskatchewan Cancer Foundation;
- St. Louis Alcoholism Rehabilitation Centre; and
- The Saskatchewan Health Information Network (SHIN).

These agencies also provide their own annual reports that are directly available to the public. Because districts and agencies provide this separate public reporting, Saskatchewan Health does not consolidate the results of these separate legal entities with the department's financial reporting.

Saskatchewan Health Comparison of Actual Revenue and Expenditure to Estimates

	2001-02 Estimates $000s	2001-02 Actuals $000s	Variance $000s *
HEALTH			
Revenue	17,566	15,707	(1,859)
Operating Expenditures:			
Administration	3,407	3,370	(37)
Accommodation & Central Services	4,082	4,209	127
District Health Services & Support			
Acute & Rehabilitation Services	784,454	792,565	8,111
Long Term Care Services	327,051	326,284	(767)
Home-Based Services	86,492	87,255	763
Community Services	134,784	128,368	(6,416)
Emergency Response Services	29,258	27,881	(1,377)
Health Facilities - Capital	25,085	25,037	(48)
Medical Equipment	23,265	23,213	(52)
District Programs Support	14,260	13,720	(540)
SUBTOTAL	1,424,649	1,414,323	(326)
Provincial Health Services & Support			
Saskatchewan Cancer Agency	33,989	34,127	138
Canadian Blood Services	26,952	29,825	2,873
Health Organizations and Services	12,487	13,147	660
Provincial Laboratory	10,197	10,656	459
Health Research	5,233	5,233	-
Immunizations	4,608	5,136	528
Saskatchewan Health Information Network	10,600	10,600	-
Provincial Programs Support	15,799	15,666	(133)
SUBTOTAL	119,865	124,390	4,525
Medical Services & Medical Education Programs	488,997	482,602	(6,395)
Drug Plan & Extended Benefits	160,628	159,072	(1,556)
Early Childhood Development	5,600	1,787	(3,813)
TOTAL OPERATING EXPENDITURES	**2,207,228**	**2,199,753**	**(7,475)**
FTE STAFF COMPLEMENT	**584.5**	**613.0**	**28.5**

Financial Statements
District Health Board audited operating fund

STATEMENT OF OPERATIONS	Assiniboine Valley	Battlefords	Central Plains	East Central	Gabriel Springs	Greenhead	Keewatin Yatthe'	Living Sky	Lloydminster
Operating Revenues:									
Saskatchewan Health -									
General Revenue Fund	21,380,487	55,288,636	21,886,539	54,012,902	11,208,114	12,095,867	12,706,963	14,655,315	9,187,410
Long-term Resident and Respite Income	2,835,923	3,237,519	2,684,661	4,443,187	23,538	1,393,774	-	2,263,402	1,660,219
Home Based Services - Client Fees	126,751	118,491	211,333	238,701	87,367	141,577	7,413	139,267	82,689
Emergency Response Service Fees	-	-	40,769	62,175	-	243,472	379,671	93,237	-
CMHC Mortgage Subsidies	-	-	-	-	-	-	-	20,534	64,084
Out-of-Province/Third Party Reimbursements	236,075	819,867	19,021	1,672,019	105,186	77,902	97,348	102,854	438,323
Donations	-	66,454	16,927	11,297	12,157	-	-	-	61,375
Investment Income	17,065	154,837	110,455	-	74,876	-	8,801	3,617	210,176
Ancillary Operations	-	666,811	29,409	-	-	-	-	32,070	-
Other	673,997	957,489	481,146	1,772,981	88,139	436,908	193,976	432,159	11,779,525
Total Operating Revenue	**25,270,298**	**61,310,104**	**25,480,260**	**62,213,262**	**11,599,377**	**14,389,500**	**13,394,172**	**17,742,455**	**23,483,801**
Operating Expenses:									
Acute Services	8,392,768	20,475,956	2,358,327	26,075,389	4,007,883	5,161,155	4,587,804	5,532,842	11,429,467
Specialized Hospital Programs	-	14,394,882	-	652,972	-	-	-	-	-
Supportive Care Services	12,617,553	14,725,147	10,964,883	20,750,552	-	4,976,292	-	8,417,997	8,475,176
Grants to Affiliates:									
Acute Services	-	-	6,573,614	-	-	-	2,859,611	-	-
Supportive Care Services	-	926,123	1,173,685	-	4,844,527	1,082,166	-	-	-
Other	-	-	-	-	-	-	-	-	-
Home Based Services	2,414,816	1,938,085	2,341,024	4,172,586	1,023,753	1,429,167	940,046	1,673,240	1,268,295
Health Improvement Initiatives:									
Health, Wellness and Social Centres	-	-	310,683	-	-	-	-	301,804	78,766
Rural Health Initiatives	300,971	185,638	449,168	488,435	144,498	404,213	-	190,036	67,799
Community Care Initiatives	115,156	-	6,095	189,142	-	39,153	721,562	-	87,088
Emergency Response Services	982,110	555,917	814,749	858,176	331,246	672,070	873,298	712,808	348,058
Alcohol and Drug Services	56,628	562,549	134,872	260,351	51,935	67,861	877,688	27,879	438,847
Community Health Services	438,444	2,962,689	453,987	2,224,870	266,302	526,558	1,988,431	377,216	698,929
Mental Health Services	73,771	5,751,734	156,776	5,600,594	162,612	59,127	-	104,425	847,009
Rehabilitation Services	175,726	563,511	394,965	373,434	141,936	53,612	199,409	131,648	710,317
Ancillary Operations	-	-	29,840	-	-	-	-	1,580	-
Other	-	-	57,050	216,645	896,440	-	-	-	-
Total Operating Expenses	**25,567,943**	**63,042,231**	**26,219,718**	**61,863,146**	**11,871,132**	**14,471,374**	**13,047,849**	**17,471,475**	**24,449,751**
Operating Fund Excess/(Deficiency) of Revenues over Expenses	**(297,645)**	**(1,732,127)**	**(739,458)**	**350,116**	**(271,755)**	**(81,874)**	**346,323**	**270,980**	**(965,950)**
Operating Fund Balance - Beginning of the year	(1,432,676)	(1,097,996)	1,052,354	(16,055,624)	658,516	(1,012,201)	39,386	(1,945,036)	3,411,673
Interfund Transfers	(320,984)	(68,224)	(312,895)	(644,798)	-	-	-	(270,980)	(32,950)
Equity Adjustments-	-	18,287	-	-	-	(15,577)	-	-	-
Total Adjustments to Equity	(320,984)	(49,937)	(312,895)	(644,798)	-	(15,577)	-	(270,980)	(32,950)
Operating Fund Balance - End of Year	(2,051,305)	(2,880,060)	1	(16,350,306)	386,761	(1,109,652)	385,709	(1,945,036)	2,412,773
STATEMENT OF FINANCIAL POSITION									
Operating Assets:									
Cash and Short-term Investments	42,137	3,996,597	1,797,767	11,439	219,361	(491,319)	763,309	204,313	4,548,823
Accounts Receivable:									
Saskatchewan Health	167,986	-	205,123	368,558	64,494	-	378,361	137,796	104,711
Other	284,936	1,235,631	520,833	1,102,562	245,266	264,235	897,380	234,833	586,342
Inventory	616,298	552,107	233,170	645,143	130,423	237,120	103,146	415,344	513,399
Prepaid Expenses	209,829	301,358	105,885	338,970	14,243	58,323	12,899	64,087	251,534
Investments	-	521,942	-	-	662,186	-	-	20,059	184,815
Restricted Assets	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-
Total Operating Assets	**1,321,186**	**6,607,635**	**2,862,778**	**2,466,672**	**1,335,973**	**68,359**	**2,155,095**	**1,076,432**	**6,189,624**
Liabilities and Operating Fund Balance:									
Accounts Payable	713,585	2,877,391	341,209	1,081,495	320,529	223,548	633,449	599,487	1,069,877
Bank Indebtedness	-	-	-	10,544,119	-	-	-	1,026,563	-
Accrued Liabilities	2,428,105	5,140,089	1,678,502	6,572,362	561,658	687,649	861,792	1,389,557	2,527,465
Deferred Revenue	230,801	1,470,215	843,066	619,002	67,025	266,814	274,145	5,861	179,509
Total Liabilities	**3,372,491**	**9,487,695**	**2,862,777**	**18,816,978**	**949,212**	**1,178,011**	**1,769,386**	**3,021,468**	**3,776,851**
Externally Restricted	-	-	-	-	-	-	-	-	-
Internally Restricted	-	-	-	-	40,755	-	-	-	157,889
Unrestricted	(2,051,305)	(2,880,060)	1	(16,350,306)	346,006	(1,109,652)	385,709	(1,945,036)	2,254,884
Operating Fund Balance	**(2,051,305)**	**(2,880,060)**	**1**	**(16,350,306)**	**386,761**	**(1,109,652)**	**385,709**	**(1,945,036)**	**2,412,773**
Total Liabilities and Operating Fund Balance	**1,321,186**	**6,607,635**	**2,862,778**	**2,466,672**	**1,335,973**	**68,359**	**2,155,095**	**1,076,432**	**6,189,624**

Financial Statements
District Health Board audited operating fund

STATEMENT OF OPERATIONS	Mamawetan Churchill River	Midwest	Moose Jaw - Thunder Creek	Moose Mountain	North Central	North-East
Operating Revenues:						
Saskatchewan Health - General Revenue Fund	13,880,280	19,929,522	55,878,544	13,073,546	17,931,772	16,875,316
Long-term Resident and Respite Income	157,315	2,684,868	1,319,426	1,517,777	1,657,996	1,782,670
Home Based Services - Client Fees	32,065	218,760	270,903	139,177	188,719	154,390
Emergency Response Service Fees	-	269,992	113,530	225,367	-	-
CMHC Mortgage Subsidies	-	143,594	67,887	-	112,352	-
Out-of-Province/Third Party Reimbursements	51,916	93,506	525,007	306,549	124,685	91,823
Donations	-	-	49,961	-	-	20,789
Investment Income	16,176	151,106	247,694	80,154	130,775	79,707
Ancillary Operations	303,923	-	161,953	-	81,988	350,045
Other	149,476	685,979	1,743,667	324,538	549,245	-
Total Operating Revenue	**14,591,151**	**24,177,327**	**60,378,572**	**15,867,108**	**20,777,532**	**19,354,740**
Operating Expenses:						
Acute Services	5,030,419	4,796,758	26,160,675	5,788,135	7,495,054	5,900,016
Specialized Hospital Programs	-	-	368,666	-	-	-
Supportive Care Services	-	12,907,219	6,983,781	6,912,573	8,248,171	7,970,793
Grants to Affiliates:						
Acute Services	-	-	-	-	-	-
Supportive Care Services	-	-	10,826,804	-	-	-
Other	-	-	1,398,313	-	-	-
Home Based Services	1,033,347	2,509,037	4,256,965	1,686,310	1,526,243	1,266,347
Health Improvement Initiatives:						
Health, Wellness and Social Centres	-	699,500	84,548	87,412	-	645,474
Rural Health Initiatives	-	307,872	1,014,796	226,210	272,145	303,791
Community Care Initiatives	14,567	74,881	269,000	92,580	59,252	58,302
Emergency Response Services	573,185	793,220	1,000,916	315,291	331,905	450,195
Alcohol and Drug Services	983,357	73,871	250,090	112,799	233,520	970,228
Community Health Services	3,658,785	1,536,591	2,439,755	385,529	1,654,540	292,742
Mental Health Services	805,723	247,903	4,017,354	232,852	274,478	235,960
Rehabilitation Services	230,428	81,407	720,425	214,584	420,805	166,370
Ancillary Operations	-	-	111,135	-	-	-
Other	2,302,303	385,000	-	-	311,385	1,163,580
Total Operating Expenses	**14,632,114**	**24,413,259**	**59,903,223**	**16,054,275**	**20,827,498**	**19,423,798**
Operating Fund Excess/(Deficiency) of Revenues over Expenses	**(40,963)**	**(235,932)**	**475,349**	**(387,167)**	**(49,966)**	**(69,058)**
Operating Fund Balance - Beginning of the year	(417,225)	1,092,488	1,893,613	1,044,350	1,862,954	585,542
Interfund Transfers	-	(64,534)	(475,000)	(221,096)	(509,380)	(29,850)
Equity Adjustments	-	-	-	-	-	-
Total Adjustments to Equity	-	(64,534)	(475,000)	(221,096)	(509,380)	(29,850)
Operating Fund Balance - End of Year	(458,188)	792,022	1,893,962	436,087	1,303,608	486,634
STATEMENT OF FINANCIAL POSITION						
Operating Assets:						
Cash and Short-term Investments	723,374	3,847,929	7,297,620	1,640,671	2,605,960	1,142,162
Accounts Receivable:						
Saskatchewan Health	247,106	155,123	566,719	113,455	134,854	-
Other	239,719	468,800	620,353	235,044	185,925	379,559
Inventory	96,280	411,106	578,989	239,435	188,456	315,280
Prepaid Expenses	45,634	203,939	527,522	100,451	246,121	23,544
Investments	-	-	58,500	-	-	550,000
Restricted Assets	-	-	-	-	-	-
Other	-	-	-	-	-	12,404
Total Operating Assets	**1,352,113**	**5,086,897**	**9,649,703**	**2,329,056**	**3,361,316**	**2,422,949**
Liabilities and Operating Fund Balance:						
Accounts Payable	732,113	889,213	1,802,371	617,774	76,888	399,733
Bank Indebtedness	-	-	-	-	-	-
Accrued Liabilities	860,878	1,899,597	3,775,878	1,231,104	1,936,341	1,398,149
Deferred Revenue	217,310	1,506,065	2,177,492	44,091	44,479	138,433
Total Liabilities	1,810,301	4,294,875	7,755,741	1,892,969	2,057,708	1,936,315
Externally Restricted	-	-	-	-	-	-
Internally Restricted	-	-	651,749	256,031	-	-
Unrestricted	(458,188)	792,022	1,242,213	180,056	1,303,608	486,634
Operating Fund Balance	**(458,188)**	**792,022**	**1,893,962**	**436,087**	**1,303,608**	**486,634**
Total Liabilities and Operating Fund Balance	**1,352,113**	**5,086,897**	**9,649,703**	**2,329,056**	**3,361,316**	**2,422,949**

Financial Statements
District Health Board audited operating fund

STATEMENT OF OPERATIONS	North Valley	Northwest	Parkland	Pasquia	Pipestone
Operating Revenues:					
Saskatchewan Health - General Revenue Fund	17,820,154	11,057,674	17,384,691	18,608,400	22,290,964
Long-term Resident and Respite Income	2,564,366	1,117,799	2,027,954	2,091,674	3,346,892
Home Based Services - Client Fees	122,069	66,390	142,904	198,229	214,627
Emergency Response Service Fees	264,561	450,074	-	118,902	245,600
CMHC Mortgage Subsidies	-	62,707	317,479	139,341	104,640
Out-of-Province/Third Party Reimbursements	188,904	106,162	219,555	138,023	942,544
Donations	-	19,646	-	-	-
Investment Income	34,001	131,120	13,888	96,960	15,256
Ancillary Operations	140,936	-	-	33,853	-
Other	511,028	536,474	243,637	303,393	132,743
Total Operating Revenue	**21,646,019**	**13,548,046**	**20,350,108**	**21,928,775**	**27,293,266**
Operating Expenses:					
Acute Services	7,097,183	5,717,868	4,536,849	8,683,767	7,639,326
Specialized Hospital Programs	-	-	-	399,001	-
Supportive Care Services	11,222,652	4,471,866	10,697,591	8,463,451	14,497,879
Grants to Affiliates:					
Acute Services	-	-	-	-	-
Supportive Care Services	-	-	-	-	-
Other	-	-	-	-	-
Home Based Services	1,562,129	781,944	2,566,405	1,922,608	1,873,017
Health Improvement Initiatives:					
Health, Wellness and Social Centres	342,989	129,201	-	250,881	533,448
Rural Health Initiatives	407,477	135,121	279,859	360,319	544,487
Community Care Initiatives	28,039	76,052	-	57,094	-
Emergency Response Services	784,468	993,525	625,352	835,310	880,713
Alcohol and Drug Services	120,933	188,838	93,702	57,229	913,640
Community Health Services	323,464	491,935	369,823	609,153	380,733
Mental Health Services	48,349	227,083	120,196	228,211	301,441
Rehabilitation Services	298,440	171,959	262,731	139,785	151,322
Ancillary Operations	-	-	-	-	-
Other	-	-	964,960	-	-
Total Operating Expenses	**22,236,123**	**13,385,392**	**20,537,468**	**22,006,809**	**27,815,006**
Operating Fund Excess/(Deficiency) of Revenues over Expenses	**(590,104)**	**162,654**	**(187,360)**	**(78,034)**	**(522,740)**
Operating Fund Balance - Beginning of the year	(2,190,966)	2,264,193	(1,176,945)	1,644,494	(1,132,154)
Interfund Transfers	80,778	(150,000)	(227,652)	(342,848)	(281,612)
Equity Adjustments	-	-	-	-	-
Total Adjustments to Equity	80,778	(150,000)	(227,652)	(342,848)	(281,612)
Operating Fund Balance - End of Year	(2,700,292)	2,276,847	(1,591,957)	1,223,612	(1,936,506)
STATEMENT OF FINANCIAL POSITION					
Operating Assets:					
Cash and Short-term Investments	400,136	1,916,876	118,593	2,726,736	227,927
Accounts Receivable:					
Saskatchewan Health	-	88,389	140,293	206,931	220,675
Other	447,087	384,637	321,478	259,599	618,563
Inventory	310,248	214,707	142,439	500,400	377,092
Prepaid Expenses	195,169	78,482	72,946	213,117	311,727
Investments	427,866	1,407,319	-	-	21,300
Restricted Assets	-	-	-	-	-
Other	-	-	-	-	-
Total Operating Assets	**1,780,506**	**4,090,410**	**795,749**	**3,906,783**	**1,777,284**
Liabilities and Operating Fund Balance:					
Accounts Payable	629,273	443,607	408,502	722,817	770,356
Bank Indebtedness	1,369,596	-	-	-	-
Accrued Liabilities	2,255,977	1,193,546	1,775,312	1,782,874	2,764,408
Deferred Revenue	225,952	176,410	203,892	177,480	179,026
Total Liabilities	4,480,798	1,813,563	2,387,706	2,683,171	3,713,790
Externally Restricted	-	-	-	-	-
Internally Restricted	543,768	-	-	-	-
Unrestricted	(3,244,060)	2,276,847	(1,591,957)	1,223,612	(1,936,506)
Operating Fund Balance	**(2,700,292)**	**2,276,847**	**(1,591,957)**	**1,223,612**	**(1,936,506)**
Total Liabilities and Operating Fund Balance	**1,780,506**	**4,090,410**	**795,749**	**3,906,783**	**1,777,284**

Financial Statements
District Health Board audited operating fund

STATEMENT OF OPERATIONS	Prairie West	Prince Albert	Regina	Rolling Hills	Saskatoon	South Central
Operating Revenues:						
Saskatchewan Health - General Revenue Fund	13,839,678	68,122,866	362,150,000	9,589,123	384,523,000	32,231,722
Long-term Resident and Respite Income	1,850,866	2,830,887	2,576,000	782,392	-	3,349,717
Home Based Services - Client Fees	160,849	174,171	696,000	137,399	-	159,304
Emergency Response Service Fees	346,577	-	2,909,000	34,610	-	404,756
CMHC Mortgage Subsidies	151,420	-	-	20,534	-	-
Out-of-Province/Third Party Reimbursements	125,635	730,261	12,464,000	34,830	15,947,000	118,470
Donations	2,119	17,270	530,000	-	-	8,634
Investment Income	120,888	87,594	151,000	74,861	-	277,719
Ancillary Operations	141,022	980,051	2,943,000	14,331	-	-
Other	456,555	2,415,980	10,583,000	128,685	4,872,000	825,377
Total Operating Revenue	**17,195,609**	**75,359,080**	**395,002,000**	**10,816,765**	**405,342,000**	**37,375,699**
Operating Expenses:						
Acute Services	4,201,950	38,272,985	233,136,000	1,362,142	293,838,000	7,367,013
Specialized Hospital Programs	-	1,001,686	20,766,000	-	-	-
Supportive Care Services	8,153,848	11,856,712	25,120,000	4,018,695	15,878,000	16,782,461
Grants to Affiliates:						
Acute Services	-	-	-	-	-	-
Supportive Care Services	-	4,655,637	42,514,000	2,225,308	40,788,000	1,780,682
Other	-	-	-	-	-	231,388
Home Based Services	1,382,122	4,750,356	14,642,000	1,084,024	16,125,000	2,131,328
Health Improvement Initiatives:						
Health, Wellness and Social Centres	854,909	923,540	254,000	925,239	935,000	974,799
Rural Health Initiatives	292,563	840,025	2,008,000	226,633	59,000	563,884
Community Care Initiatives	47,035	706,730	592,000	19,898	745,000	241,503
Emergency Response Services	774,751	830,427	4,720,000	376,504	2,035,000	962,426
Alcohol and Drug Services	135,032	678,257	2,006,000	51,762	3,913,000	123,313
Community Health Services	441,860	3,621,177	12,569,000	210,126	10,644,000	1,792,368
Mental Health Services	301,868	6,290,552	15,811,000	43,830	13,500,000	3,717,372
Rehabilitation Services	98,212	-	25,344,000	101,066	12,970,000	475,776
Ancillary Operations	42,223	596,574	1,109,000	28,556	-	-
Other	-	-	374,000	-	-	-
Total Operating Expenses	**16,726,373**	**75,024,658**	**400,965,000**	**10,673,783**	**411,430,000**	**37,144,313**
Operating Fund Excess/(Deficiency) of Revenues over Expenses	**469,236**	**334,422**	**(5,963,000)**	**142,982**	**(6,088,000)**	**231,386**
Operating Fund Balance - Beginning of the year	782,900	(2,772,176)	(36,310,000)	837,755	(12,106,000)	2,646,804
Interfund Transfers	(466,947)	(334,422)	-	(355,514)	-	328,844
Equity Adjustments	-	-	-	-	-	-
Total Adjustments to Equity	(466,947)	(334,422)	-	(355,514)	-	328,844
Operating Fund Balance - End of Year	785,189	(2,772,176)	(42,273,000)	625,223	(18,194,000)	3,207,034
STATEMENT OF FINANCIAL POSITION						
Operating Assets:						
Cash and Short-term Investments	823,721	2,672,943	739,000	1,080,424	14,580,000	4,168,029
Accounts Receivable:						
Saskatchewan Health	108,361	435,497	5,150,000	54,917	8,929,000	276,932
Other	272,298	1,285,157	7,397,000	92,261	10,633,000	433,836
Inventory	321,081	527,910	3,654,000	209,521	5,734,000	563,610
Prepaid Expenses	39,592	816,422	1,636,000	25,839	1,578,000	73,100
Investments	1,273,466	-	1,229,000	390,891	-	2,499,265
Restricted Assets	-	-	-	-	-	-
Other	-	-	11,026,000	-	-	-
Total Operating Assets	**2,838,519**	**5,737,929**	**30,831,000**	**1,853,853**	**41,454,000**	**8,014,772**
Liabilities and Operating Fund Balance:						
Accounts Payable	780,545	2,776,576	19,425,000	376,556	24,414,000	1,585,382
Bank Indebtedness	-	-	17,361,000	-	-	-
Accrued Liabilities	1,076,769	5,054,602	30,384,000	650,557	29,758,000	2,964,369
Deferred Revenue	196,016	678,927	5,934,000	201,517	5,476,000	257,987
Total Liabilities	2,053,330	8,510,105	73,104,000	1,228,630	59,648,000	4,807,738
Externally Restricted	-	-	-	-	-	1,227,880
Internally Restricted	-	-	-	345,465	-	1,266,487
Unrestricted	785,189	(2,772,176)	(42,273,000)	279,758	(18,194,000)	712,667
Operating Fund Balance	**785,189**	**(2,772,176)**	**(42,273,000)**	**625,223**	**(18,194,000)**	**3,207,034**
Total Liabilities and Operating Fund Balance	**2,838,519**	**5,737,929**	**30,831,000**	**1,853,853**	**41,454,000**	**8,014,772**

Financial Statements
District Health Board audited operating fund

STATEMENT OF OPERATIONS	South Country	South East	Southwest	Swift Current	Touchwood Qu'Appelle	Twin Rivers	Grand Total
Operating Revenues:							
Saskatchewan Health - General Revenue Fund	12,053,015	21,439,253	13,354,516	32,366,536	11,547,966	10,232,588	1,408,803,359
Long-term Resident and Respite Income	1,306,202	2,596,053	1,819,425	2,335,858	1,517,030	1,288,601	61,063,991
Home Based Services - Client Fees	128,191	217,970	125,907	124,574	116,740	130,826	5,073,753
Emergency Response Service Fees	-	540,554	273,710	-	-	229,652	7,246,209
CMHC Mortgage Subsidies	-	-	-	-	-	41,161	1,245,733
Out-of-Province/Third Party Reimbursements	252,671	41,903	246,231	226,369	54,995	111,481	36,711,075
Donations	795	7,841	17,869	94,954	-	156,953	1,095,041
Investment Income	22,911	28,595	84,123	79,595	88,610	33,874	2,626,434
Ancillary Operations	27,178	-	14,375	198,832	-	44,751	6,164,528
Other	27,574	742,571	231,433	1,275,859	196,296	275,130	44,026,960
Total Operating Revenue	**13,818,537**	**25,614,740**	**16,167,589**	**36,702,577**	**13,521,597**	**12,545,017**	**1,574,057,083**
Operating Expenses:							
Acute Services	2,646,836	-	5,150,353	17,710,344	2,528,907	4,123,306	787,205,477
Specialized Hospital Programs	-	-	-	455,626	-	-	38,038,833
Supportive Care Services	5,002,637	9,702,652	7,375,222	10,774,794	6,241,875	5,001,520	299,211,992
Grants to Affiliates:							
Acute Services	1,277,277	6,834,886	-	-	1,630,045	-	19,175,433
Supportive Care Services	1,364,143	2,476,840	-	-	287,655	-	114,945,570
Other	-	119,910	-	-	-	-	1,749,611
Home Based Services	1,393,786	2,343,600	1,761,124	2,299,581	1,269,379	1,237,314	88,604,978
Health Improvement Initiatives:							
Health, Wellness and Social Centres	341,948	1,447,447	527,663	-	43,736	814,351	11,607,338
Rural Health Initiatives	562,528	518,324	176,820	300,585	504,261	268,078	12,403,536
Community Care Initiatives	95,503	-	16,739	108,064	84,346	-	4,544,781
Emergency Response Services	476,133	1,012,995	803,030	390,396	515,988	609,751	27,239,913
Alcohol and Drug Services	63,952	-	67,663	190,849	67,956	49,075	13,823,676
Community Health Services	469,611	483,386	341,906	1,729,146	143,205	224,729	54,750,990
Mental Health Services	123,314	677,057	82,993	2,593,218	63,780	68,886	62,769,468
Rehabilitation Services	67,456	294,770	95,809	66,723	102,542	47,807	45,266,975
Ancillary Operations	-	-	19,191	63,608	-	-	2,001,707
Other	-	-	-	-	-	-	6,691,363
Total Operating Expenses	**13,885,124**	**25,911,867**	**16,418,513**	**36,682,934**	**13,483,675**	**12,444,817**	**1,590,031,641**
Operating Fund Excess/(Deficiency) of Revenues over Expenses	**(66,587)**	**(297,127)**	**(250,924)**	**19,643**	**37,922**	**100,200**	**(15,974,558)**
Operating Fund Balance - Beginning of the year	(220,055)	(145,704)	792,445	(963,157)	638,472	(861,712)	(58,591,688)
Interfund Transfers	-	(22,416)	(170,985)	(19,643)	(248,409)	1,685	(5,159,832)
Equity Adjustments	-	-	-	-	-	-	2,710
Total Adjustments to Equity	-	(22,416)	(170,985)	(19,643)	(248,409)	1,685	(5,157,122)
Operating Fund Balance - End of Year	(286,642)	(465,247)	370,536	(963,157)	427,985	(759,827)	(79,723,368)
STATEMENT OF FINANCIAL POSITION							
Operating Assets:							
Cash and Short-term Investments	568,234	887,109	2,066,168	2,125,048	2,438,182	88,509	65,977,778
Accounts Receivable:							
Saskatchewan Health	117,709	170,839	112,120	504,347	95,959	80,092	19,336,347
Other	400,810	463,197	176,124	1,027,575	92,039	276,361	32,082,440
Inventory	112,013	38,639	357,260	455,117	197,581	299,580	19,290,894
Prepaid Expenses	33,426	140,612	72,602	61,691	30,661	48,915	7,932,640
Investments	-	102,675	-	-	-	178,113	9,527,397
Restricted Assets	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	11,038,404
Total Operating Assets	**1,232,192**	**1,803,071**	**2,784,274**	**4,173,778**	**2,854,422**	**971,570**	**165,185,900**
Liabilities and Operating Fund Balance:							
Accounts Payable	516,121	568,934	622,056	1,456,675	451,658	603,781	68,930,501
Bank Indebtedness	-	-	-	-	-	-	30,301,278
Accrued Liabilities	1,002,713	1,544,225	1,585,320	3,154,337	1,692,178	881,555	122,469,868
Deferred Revenue	-	155,159	202,362	525,923	282,601	246,061	23,207,621
Total Liabilities	1,518,834	2,268,318	2,413,738	5,136,935	2,426,437	1,731,397	244,909,268
Externally Restricted	-	-	31,616	-	-	-	1,259,496
Internally Restricted	-	-	63,674	21,493	18,029	-	3,365,340
Unrestricted	(286,642)	(465,247)	275,246	(984,650)	409,956	(759,827)	(84,348,204)
Operating Fund Balance	**(286,642)**	**(465,247)**	**370,536**	**(963,157)**	**427,985**	**(759,827)**	**(79,723,368)**
Total Liabilities and Operating Fund Balance	**1,232,192**	**1,803,071**	**2,784,274**	**4,173,778**	**2,854,422**	**971,570**	**165,185,900**

Note: Certain figures have been reclassified to conform to this format.

Note: Individual District Health Boards' audited financial statements are available from the Health District.

1. Regina does not present their Statement of Financial Position in this format; therefore, these detailed numbers are considered unaudited.
2. Keewatin Yatthé, Parkland and Twin Rivers Health District's Final Financial Statements have not yet been received by the Department, therefore draft financial statement information has been used.

Performance Plan

OVERVIEW

The purpose of an annual report is not only to look back at the year past, but also to look forward — to provide a forecast of the challenges and opportunities ahead, and how we plan to address them.

In this annual report, for the first time ever, Saskatchewan Health is publishing its performance plan. This performance plan speaks to the fiscal year 2002-03, and beyond.

The plan draws heavily on *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care*, which was introduced by government in December of last year. The Action Plan is a broad strategic plan that outlines our vision and goals for the future of the health system, and provides a blueprint to ensure the continued delivery of accessible, quality health care in Saskatchewan.

The performance plan contained in the following pages clearly outlines a number of key objectives that will guide our department over the next several years, as well as specific actions that will be taken during 2002-03 to help fulfill those objectives. Further, this performance plan provides a number of performance measures to help evaluate our progress on each objective. This progress will be reported on a year from now in the 2002-03 Annual Report.

In spite of the challenges we face, we know that our health system is fundamentally sound. We are providing strong leadership, while working together to make the changes needed to strengthen and sustain the system for the future.

It is important that Saskatchewan people have the facts they need to be informed partners in this process. This new planning and reporting framework will be refined in coming years as our ability to measure outcomes in health care progresses. By reporting on the challenges we face, our plans, actions and what we achieve, we will be better able to evaluate the effectiveness of the services we provide, and demonstrate results to the people we serve.

BUDGET OVERVIEW

In 2002-03, our province will spend more than $2.3 billion on health care, a 6.2 per cent increase over the previous year's budget. This is the most ever invested in our province's health care system, and amounts to approximately 40 per cent of our provincial spending on programs and services.

When compared to other provinces, our provincial government spending per capita on health care tends to rank in the middle of the pack.

Spending on health care in Saskatchewan supports a wide range of programs and services including hospital and emergency medical care, education to help prevent disease and injury, the provincial drug plan, services for seniors, and the maintenance of a strong dedicated workforce.

More specifically, the 2002-03 budget will help Saskatchewan Health move ahead on several key priorities in the Health Action Plan aimed at improving quality of health services and access to care while ensuring wise use of health dollars. These include retaining and recruiting health providers, improving management of waiting times for surgery, supporting our province's new regional health authorities, improving access to primary health care services, increasing health research spending and establishing Canada's first Quality Council, an advisory body to promote excellence and effective health spending.

The following is a breakdown of the major areas of spending for our province's health budget.

2002-03 Budget
(in thousands of dollars)

	Estimated 2002-03
Administration	3,400
Accommodation & Central Services	4,702
Regional Health Services & Support	1,501,214
Provincial Health Services & Support	134,159
Medical Services & Medical Education Programs	527,554
Drug Plan & Extended Benefits	167,279
Early Childhood Development	4,108
Total	2,342,416*

* Includes an additional $7.4 million to reflect further estimates.

TRENDS AND ISSUES

As we move into the 21st century, governments across Canada are grappling with the many challenges of managing a publicly funded, publicly administered health system. In Saskatchewan we are now implementing *The Action Plan for Saskatchewan Health Care* which responds to the Report from Saskatchewan's Commission on Medicare chaired by Ken Fyke.

In Saskatchewan, we face a number of challenges that must be considered when developing strategic directions.

Changing Demographics

Saskatchewan's overall population numbers are relatively stable, but the composition is changing:

- We have a growing population of elderly people;
- People of Aboriginal ancestry are expected to represent roughly 33 per cent of the total Saskatchewan population within the next 30 years;
- Significant numbers of both residents over 65 and Aboriginal peoples live in rural areas.

Studies show that these groups tend to use more health services, emphasizing the need for us to focus on providing services in the best way possible in rural and remote areas.

Furthermore, with 42 per cent of Saskatchewan seniors and 65 per cent of Aboriginal people living in rural areas, access and service delivery issues will require effective human resource and health service planning. Additional pressures arise from the need to provide health services to northern and remote regions of the province.

Health Care Providers

With increasing competition for health care providers across North America, keeping and attracting the doctors, nurses and other health professionals we need is an ongoing concern. The continuing challenge to fill vacancies while meeting patient needs, leads to increased demands (e.g. overtime and risk of burn-out) on existing staff.

Public Confidence and Expectations

A recent poll of Saskatchewan residents indicates that 85.9 per cent of those who received health care rated the quality of care as good or excellent. However, when the general population is asked to rate the overall level of health services in Saskatchewan, their confidence is much lower.

Our health system cannot survive without the support of Saskatchewan people. While our residents generally feel good about the services they receive today, many feel insecure about the future and the ability of the health system to continue to meet their needs.

Waiting times for surgery are a major concern for Saskatchewan people. By working together on a number of long-term actions, we can progress toward a more reasonable, fair surgical system that earns the confidence and trust of Saskatchewan people.

Determinants of Health

We know that many broad factors other than doctors and hospitals can improve our health. These include a clean environment, a good job, social supports and decent housing. Saskatchewan Health recognizes the benefits of placing more emphasis on addressing these determinants, rather than simply treating the results of poor health. However, these factors are often viewed as competing priorities. The challenge is to balance the more pressing needs of the hospital sector with the less immediate benefits of supporting and encouraging a healthier population.

An Effective, Sustainable Health System

Total health care spending in Canada is growing rapidly. In our province alone, the average growth in the health budget since 1995-96 has been over six per cent a year, well above our rate of economic growth. Sustaining health care costs means diverting resources from other areas such as education, housing and social supports, each of which plays an important role in promoting individual health, as well as potential loss of growth opportunities for the province.

Performance Plan

Given the limited number of health dollars, we need to ensure quality and efficiency for every health dollar spent. This means improving service delivery to provide the greatest benefit to patients, improving co-operation between all partners in the health system, and making better use of research to ensure we make decisions based on evidence.

Where we are headed, what we intend to do and how we will measure progress

In December 2001, Saskatchewan Health unveiled *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care.* The action plan is a blueprint for the future of health services in Saskatchewan. It reaffirms the government's commitment to take a strong leadership role in making necessary changes, and states its top priority: improving the quality of services and access to care, while ensuring the health system is sustainable into the future.

Our Vision

This document is built on the work done in the action plan, and identifies the following vision statement:

Building a province of healthy people and healthy communities

Our Goals

To achieve this ideal, Saskatchewan Health has identified the following long-term goals:

Goal One: Improved access to quality health services.

Goal Two: Effective health promotion and disease prevention.

Goal Three: Retain, recruit and train health providers.

Goal Four: A sustainable, efficient, accountable and quality health system.

Our Commitments

Saskatchewan Health is committed to implementing the Action Plan. We have already begun to act on many of the shorter-term measures to address current challenges in the system. For example, we are taking concrete steps to improve the management of surgical waiting lists, attract the doctors, nurses and other health providers we need, and improve the delivery of everyday health services in our communities. Many of these steps are reflected in the "key actions" outlined in this Performance Plan. These commitments are also reflected in our 2002-03 budget. The action plan also provides long-term direction to sustain our publicly-funded health care system into the future. It will continue to guide our decisions and investments in the health system in the years ahead.

We know that Saskatchewan Health cannot reach its goals alone. We need to work closely with the public, health providers, and a wide range of other partners including health districts, health sector unions, professional organizations, other government departments, community-based organizations and school boards.

To reflect our leadership role, we have developed a set of measurable long-term objectives for each goal. Accompanying each objective are priority actions for the coming year. All actions listed will be addressed during the 2002-03 fiscal year. We will hold ourselves accountable for completing these actions and for reaching our objectives.

We have provided a set of performance measures along with each objective. Some measure activities, others are more focused on the long-term outcomes. The selected performance measures are not in all cases the best measure. They are included here because they are the most well developed or have the best data available at this time. In future years we will continue to refine and improve the way we measure our activities. This may result in some measures being changed, new measures added and old measures dropped.

Performance Plan

Goal 1 - Improved Access To Quality Health Services

Objective 1: Responsive, co-ordinated Primary Health care

Primary health care services are generally the first point of contact for the public. This contact provides the basis to address the main health needs of individuals and communities. It is essential that these services be organized to ensure the most appropriate care, by the most appropriate providers in the most appropriate settings. Objective One is to develop primary health care networks throughout the province, offering a full range of everyday health services.

Key Actions for 2002-03

- Define primary health care networks, including core services.
- Begin development of standards for primary health care networks in areas of access, clinical standards, service standards and program requirements.
- Enhance Department and regional health authority capacity to develop and support primary health care teams.
- Regional health authorities submit plans for primary health care networks in each region.
- Develop model contracts for family physicians.
- Establish a 24-hour telephone advice line.
- Develop a proposal to access funding under the Aboriginal envelope of the Federal Primary Health Care Transition Fund.

What are we measuring?

Primary health care networks established in each regional health authority (Short-term measure)

We will measure our progress through a checklist of activities including:

- Primary health care networks defined
- Access standards for primary health care and core services defined
- Model contracts for family physicians developed
- Regional health authorities submit plans for primary health care networks in each region
- Establish performance indicators

Where are we starting from?

The creation of primary health care networks builds on the 21 demonstration sites previously developed under the Primary Health Services Initiative. Work on establishing the expanded networks began in January 2002.

What are we measuring?

Percentage of people with access to Primary Health Care networks (Medium-term measure)

The percentage of Saskatchewan people with access to a primary health care team is a good measure of a patient's access based on proximity.

Primary health care networks ensure that health care providers work together as a team to care for clients, with an emphasis on preventing illness and injury. These team members may be connected through telephone, information technology, or through face-to-face contact.

Where are we starting from?

The creation of Primary Health Care networks is a new Saskatchewan Health initiative which builds upon our 21 primary health demonstration sites and existing information networks in the province. The performance measure is currently under development.

Objective 2: Reduce waiting times for surgical procedures

Waiting times for some surgical procedures are a concern for Saskatchewan people. Saskatchewan Health will lead several initiatives designed to improve the management of wait times.

Key Actions for 2002-03

- Create a province-wide surgical waitlist registry.
- Assess all wait-listed patients using standard criteria endorsed by the Saskatchewan Surgical Care Network. This will ensure that patients get access to select surgeries based on need.
- Establish benchmark-waiting times (targets) for the various urgency rankings so patients know the maximum time they should be waiting.
- Designate surgical co-ordinators in Regina and Saskatoon.
- Launch a surgical waitlist website, providing information to the public on waitlists.

What are we measuring?

Key activities for ensuring that patients who are waiting for surgery in Saskatchewan receive the care they need within clinically appropriate timeframes and in a fair and equitable manner.

We will evaluate our progress on this measure through a checklist of activities including:

- Designate surgical co-ordinators in Regina and Saskatoon
- Establish benchmark waiting times
- Patient information website launched
- Complete surgical waitlist registry

Where are we starting from?

The preliminary results of an external review of wait list management in the province guided the strategies outlined in the Action Plan for Saskatchewan Health Care. The final Provincial Wait List Strategy Report, and its eleven recommendations, was released to the public on January 18, 2002.

What are we measuring?

Wait times for:

(a) urgent cancer patients

(b) cardiac surgery

There is provincial consensus that cancer surgery and most cardiac surgeries should be provided on an urgent basis. Saskatchewan Health is currently in the process of developing benchmark time frames for cancer, cardiac and all other surgical specialities. See key activities for managing surgical wait lists above.

Where are we starting from?

(a) Baseline to be developed. There is currently no consistency in the collection or reporting of urgent cancer wait times. The new waitlist initiative will significantly improve the public's and the department's ability to monitor ongoing trends with these waits using validated and audited provincial waitlist information.

(b) Baseline to be developed. We can currently compile data from Saskatoon and Regina based on the procedures performed, however neither district currently reports this information in a consistent form. New initiatives in this will rectify this problem, and allow for the department to provide regular reports.

Objective 3: Improve Emergency Medical Care

Saskatchewan people depend on quality emergency medical services (i.e. quick response time from well trained health providers). Over time, we will introduce regulation of ambulance fees to ensure greater fairness for all Saskatchewan people.

Key Actions for 2002-03

- Begin training emergency medical service providers up to Emergency Medical Technician (EMT)-basic level; 3-year training target of 240.
- Examine options to regulate road ambulance fees to improve consistency across the province.
- Co-ordinate all ambulance dispatch services through designated emergency medical services wide-area dispatch centres.
- Develop performance-based contracts between regional health authorities and wide-area dispatch centres.

What are we measuring?

Percentage of all ambulance calls responded to where at least one of the emergency medical service providers has at least EMT-basic level training

This measure is a reflection of the level of care that is provided by the emergency medical service provider. (Medium-term measure).

The Emergency Medical Technician (EMT) is the international standard for the basic level of service to be provided by an ambulance service.

EMT is a higher standard than Emergency Medical Responders (EMR) who must complete a recognized first aid program, CPR certification and a prescribed orientation program in ambulance operations at minimum. In comparison, EMT-basic providers receive about 400 hours of more advanced training in CPR and emergency care from an accredited Canadian Medical Association training program.

Where are we starting from?

Province-wide in 2000-01, there were 80,855 calls out of a total call volume of 82,662, or 98%, where at least one provider on the call had EMT-basic level training at minimum. All other calls had at least one EMR trained provider.

Objective 4: Improved hospital, specialized services and long-term care

Saskatchewan people depend on quality hospital and long-term care services. To strengthen our hospitals for the future, we will further develop program standards within each category of facility to promote optimal patient care across the hospital network. We will also provide more options for seniors and people with disabilities who want to remain independent in the community.

Key Actions for 2002-03

Implement hospital classification systems including continued development of standards in priority areas (e.g. intensive care, obstetrics).
Develop and implement individualized funding policy for seniors and people with disabilities.
Introduce regulatory changes for the removal of 40-bed restriction in personal care homes to allow the development of more personal care homes.
Enhance telehealth capacity in support of provincial networks and outreach programs.

What are we measuring?

Patient Satisfaction

Percentage of the adult population who rate themselves as either very satisfied or somewhat satisfied with the quality of care for:

(a) Overall health services received
(b) Services received in a hospital
(c) Services received from a family doctor or other physicians
(d) Community-based services received

Where are we starting from?

Although patient satisfaction has always been an important measure to policy makers, practitioners and the public, it is only recently that a tool has been developed to measure it. In 2000-01 the Canadian Community Health Survey (CCHS) estimates that the following proportions of Saskatchewan residents were very or somewhat satisfied with services received:

- Overall health services – 85.3%
- Hospital services – 82.9%
- Physician services – 92.6%
- Community health services – 90.3%

What are we measuring?

Expand Telehealth

(a) Number of communities with Saskatchewan telehealth networks (Short-term measure)

(b) Number of telehealth sessions, types and participants (Short-term measure)

The Telehealth network is a tool for providing clinical and educational programs for all health professionals and the general public. It also allows physicians and patients in rural and remote areas to have access to specialists in larger centres without having to travel.

Where are we starting from?

(a) There are currently 9 communities that have connections to the telehealth network.

(b) 555 telehealth sessions were conducted between July 1, 1999 and September 30, 2001. Of the 555 sessions, 265 were clinical consults while 290 were educational sessions. A total of 4,235 people attended the sessions.

Goal 2 - Effective Health Promotion and Disease Prevention

Objective 1: Better promotion of health and disease prevention

The most important influences on the health of people are factors such as income, education, diet, lifestyle (e.g. smoking), housing, environment and support from family and friends. Our plan will continue to support a variety of health promotion initiatives that improve the quality of life for Saskatchewan people. For example, an interdisciplinary approach to diabetes care will help clients to better control their disease to prevent, delay or minimize complications associated with their disease.

Key Actions for 2002-03

- Work with regional health authorities, health partners, business and community groups, to develop a provincial health promotion strategy.
- Support regional health authorities in developing, implementing and evaluating their own action plans for health promotion based on provincial priorities and local needs.
- Begin targeted screening program to assess the diabetes status of undiagnosed persons living in high-risk communities.
- Improve measurement and reporting on provincial health status including reporting on the Population Health and Dynamics Survey.
- Review regulations and related policies that support environmental health (e.g. water quality, food safety).
- Support intersectoral policy initiatives including the Child Action Plan, Early Childhood Development Plan, Youth Services Model, and the Role of the School to address the needs of children and youth, as well as the Metis and Off-Reserve Strategy.

What are we measuring?

Continue provincial diabetes strategy (Short-term measure)

We will evaluate our progress on this measure through a checklist of activities including:

(a) Establish interdisciplinary teams to provide diabetes education care and treatment

(b) Continuing professional education for health care providers

(c) Begin targeted screening program to assess the diabetes status of undiagnosed persons living in high-risk communities

(d) Implement the Diabetes Monitoring and Recall System database for client files

Where are we starting from?

A Provincial Plan for the Control of Diabetes was developed in 2001 based on information obtained from the "Diabetes 2000" report.

This plan outlines a province-wide model for the delivery of team-based services to prevent and treat diabetes. Saskatchewan Health is providing financial support to regional health authorities to implement this new model.

In early 2001, a diabetes co-ordinator was hired and implementation of the Plan started.

Performance Plan

What are we measuring?

Diabetes prevalence rate (Long-term measure)
Saskatchewan prevalence of diabetes (type 1 & 2) expressed as a number per 1,000 individuals

Type 2 diabetes affects about 90% of the diabetic population. It often appears after age 40 especially in high-risk populations and tends to be associated with inadequate nutrition, lack of exercise and obesity. Adequate public education about prevention strategies can delay or prevent type 2 diabetes.

Currently information on diabetes can be provided for prevalence rates (i.e. number of existing cases); however, the more important measure of how well prevention and promotion strategies are working is the incidence rate of diabetes (i.e. the number of new cases). In the future this measure will shift to incidence rates, as reliable data becomes available.

Where are we starting from?

The prevalence rate for diabetes (age-sex adjusted) in Saskatchewan in 1996 was 37.1 cases per 1000 population.

What are we measuring?

Percentage of daily smokers between the ages of 12-19 years in Saskatchewan (Long-term measure)

Tobacco use is the leading cause of preventable illness and death in Canada. Because of the addictive nature of nicotine, it is necessary to develop prevention and promotion strategies that deter youth from beginning to smoke.

Where are we starting from?

In 2000-01 the Canadian Community Health Survey estimates that the proportion of Saskatchewan 12-19 year olds who are current, daily or occasional smokers to be 20.5%.

Objective 2: Improve the health of Northern and Aboriginal communities

Northern and Aboriginal communities have their own issues and concerns when it comes to health care. They also have a unique perspective on how to bring better health care to their people.

Saskatchewan Health will participate in or lead a number of initiatives designed to support Northern and Aboriginal communities in their efforts to address health issues.

Key Actions for 2002-03

- Work with partners to complete a Memorandum of Understanding towards the development of a Northern Health Strategy. The Strategy works towards improved health for northern and Aboriginal peoples by placing a focus on determinants of health, collaboration with all levels of government, and recognizing the unique characteristics of these communities.
- Participate in the Government of Saskatchewan Metis and Off-Reserve First Nations People strategy, to ensure improved health status and representation in the workforce.
- Support northern hospitals, including the completion of a new Athabasca Health Facility in Stoney Rapids and the planning of a new hospital in Ile a la Crosse.
- Start construction of Fort Qu'Appelle Indian Hospital.

What are we measuring?

Potential Years of Life Lost (PYLL), per 100,000 Population, for Saskatchewan Registered Indian People (Long-term measure)

Potential Years of Life Lost is the number of years of life 'lost' when a person dies 'prematurely' from any cause – defined as dying before age 75. A person dying at age 25, for example, has lost 50 years of life. Through the development of culturally sensitive services, it is anticipated Aboriginal people will feel more comfortable being involved in programs focused on prevention and as a result, over time, we should see a decrease in the number of years of life lost by this demographic group.

Where are we starting from?

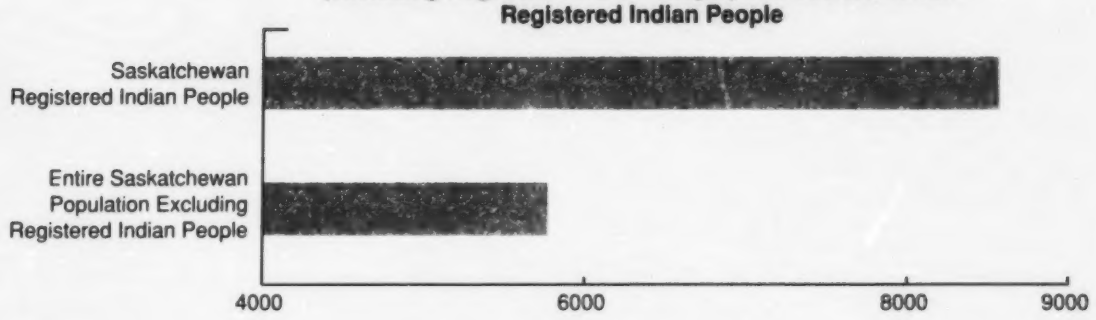
This measure focuses on deaths among the non-elderly and reflects success in preventing or postponing premature death. This premature loss of life has social and economic consequences and is an overall indicator of the effectiveness of preventive programs as well as health and well-being of the population.

It should also be noted that the Federal Government has primary responsibility with respect to "prevention" for Registered Indians.

Based on the most recent data available (1998), the years of life lost by all causes of death for Saskatchewan Registered Indian people was 8,572.6 years (as a rate per 100,000), the remainder of the Saskatchewan's population has a PYLL of 5,770.2 (as a rate per 100,000).

Performance Plan

Potential Years of Life Lost: Saskatchewan Population (excluding Registered Indian People) and Saskatchewan Registered Indian People



What are we measuring?

Health activities benefiting Northern and Aboriginal communities (Short-term measure)

This will be an activities measure, with a checklist including:

(a) Completion of Memorandum of Understanding towards the development of a Northern Health Strategy

(b) Completion of Athabasca Health Facility

(c) Begin construction of the Fort Qu'Appelle Indian Hospital

(d) Begin detailed planning of the hospital in Ile a la Crosse

Where are we starting from?

- Athabasca Health Facility is currently under-construction.
- The Functional Program (facility scope, function and cost) for the Fort Qu'Appelle Indian Hospital is currently underway.
- Initial planning has begun for the Hospital in Ile a la Crosse, detailed work needs to follow.

Goal 3 - Retain, Recruit, and Train Health Providers

Objective 1: Improve utilization and availability of health human resources

Saskatchewan's health care system faces challenges attracting and keeping skilled health professionals. We are not alone. Every other province and country faces the same challenge.

Saskatchewan's effort to deal with this issue is multi-faceted. We believe a combination of actions will be the solution: the formation of primary health care teams, training of more health care providers, supporting health professionals to make full use of their skills and training, offering competitive wages and incentives, continuing education and professional development, and increased funding for medical research.

What are we measuring?

Number of additional training seats created and type of discipline (Short-term measure)

Key Actions for 2002-03

- Implement province-wide health human resource planning to allow better utilization, retention, recruitment and training strategies.
- Support increased collaboration between provincial training institutions and regional health authorities (e.g. Academic Health Sciences Network).
- Increase numbers of training seats for select professions.
- Expand and enhance bursary programs for hard-to-fill professions.

Where are we starting from?

We will add new training seats for the providers most in need. Training seats for both nurses and physicians have been recently increased, and we will continue to monitor the need for additional spaces. In total there are 33 health professions which will be monitored.

Objective 2: Develop representative work places

Saskatchewan Health recognizes the value of a health system that meets the needs of a diverse population. Initiatives are planned to encourage a health workforce that is representative of the people it serves.

What are we measuring?

Proportion of representative work force agreements signed with health districts/regional health authorities (Medium-term measure)

The Government of Saskatchewan introduced the Aboriginal Employment Development Program in 1995 to increase Aboriginal employability and employment across the public and private sectors in Saskatchewan. The program uses formal partnership agreements that commit employers in principle to the development of three key areas: employment, education and economic development.

Key Actions for 2002-03

- Build opportunities for full participation by Aboriginal peoples through awareness training in the workplace.
- Increase Aboriginal participation in the health workforce by implementing recruitment initiatives (e.g. Representative Workforce Agreements).

Where are we starting from?

According to the Aboriginal Employment Development Program as of January 2002 there were 22 of 32 potential representative work force agreements signed. This baseline will change slightly in 2002-03 with the transition to 12 regional health authorities.

Objective 3: Create healthier more effective work places

Supporting, attracting and keeping skilled health professionals is a significant challenge for Saskatchewan's health care system. Initiatives are planned to create more satisfying work environments.

What are we measuring?

The average number of days absent from the workplace, for which illness or injury is reported as the reason for absence, within a given period of time.

Absence as a result of illness or injury (sick leave) constitutes a significant proportion of total absence from the workplace. Sick leave is a well-established indicator of quality of the workplace, staff morale and job satisfaction. Literature has shown consistently that as morale improves, rates of absenteeism decline.

Key Actions for 2002-03

- Evaluate existing quality workplace initiatives.
- Expand quality work place initiatives to include additional sites and professions.

Where are we starting from?

Baseline is under development.

Goal 4 - A Sustainable, Efficient, Accountable Quality Health System

Objective 1: Ensure quality, effective health care

To provide health services that Saskatchewan people truly need means ensuring quality is considered in all of our actions. Equally important is the need to provide the necessary support to good decision making by health professionals.

Key Actions for 2002-03

- Establish Quality Council to encourage excellence throughout the health care system.
- Progress on specific initiatives to improve health information systems to give health care providers and administrators the information they need to better co-ordinate and improve patient care.
- Continue effective and efficient administration and provision of provincially delivered health benefits and services (e.g. Drug Plan, Provincial Laboratory)
- Participate with provincial and territorial partners towards the development of a common drug review process.
- Support the College of Medicine as a key resource in the delivery of health services, in meeting provincial training needs and in conducting research.
- Increase health research funding by 40% in 2002-03.

What are we measuring?
Quality Council established

Measured by a checklist of activities to show progress including:
(a) Creation of new legislation
(b) Selection of board members
(c) CEO appointed
(d) Council mandate in place
(e) First year priorities established

Where are we starting from?
New council. Planning has just begun.

What are we measuring?
Number of competitive research grants awarded by the Canadian Institutes of Health Research (CIHR) to faculty at the University of Saskatchewan based on the number pursued as a percentage of the total number of applications (Short-term measure)

Where are we starting from?
In the 2002 CIHR funding competition, 28% of the proposals submitted by University of Saskatchewan-based researchers were successful. Saskatchewan-based researchers submitted a total of 43 proposals to the CIHR. Of these, a total of 12 were funded by the CIHR. As data becomes available, we will expand this measure to include the University of Regina.

Objective 2: Appropriate governance, accountability and management for the health sector
Strong leadership and effective planning in health care must be consistent across the province. The creation of 12 regional health authorities, governed by appointed boards, will improve the planning process for health care delivery.

A new budgeting process will allow earlier budget targeting and approval. Multi-year funding targets will allow better long-term planning.

Key Actions for 2002-03

- Implement legislation for creation of regional health authorities.
- Implement accountability framework for regional health authorities.
- Appoint new regional health authority boards and conduct board orientation.
- Develop strategy for creation of Community Advisory Networks.

What are we measuring?
Accountability framework developed and implemented (Short-term measure)

Measured by a checklist of activities to show progress including:
(a) Strategy developed to involve regional health authorities in co-ordinated province-wide planning
(b) Strategy developed for approval of regional health authority annual health plans prior to commencement of fiscal year
(c) Set of performance indicators created for regional health authority reporting
(d) Strategy developed for the creation of Community Advisory Networks
(e) Provide orientation/training to new regional health authority boards

Where are we starting from?
The government and district health boards have an existing accountability relationship which will be updated and improved with the move towards regional health authorities.

Joint planning has been initiated through the creation of the Minister's Forum and the Leadership Council.

Saskatchewan Health has provided orientation sessions to the regional health authorities.

Objective 4: Sustain publicly funded and publicly administered Medicare

Health care costs are rapidly rising. Technological advances add quality and years to people's lives, but they are expensive. People are living longer, but as our population ages more people require medications and treatments. It is also getting increasingly costly to attract and keep medical professionals who are in high demand around the world.

Saskatchewan Health will strive to make the best possible use of our health providers and our resources, through prudent management and innovative service delivery.

What are we measuring?

Public sector health expenditure as a proportion of total health expenditure (Long-term measure)

This is the share of total health expenditures (public and private) covered by the public sector. Public sector includes health care spending by provincial and municipal governments, direct health care spending by the federal government for Aboriginal people, the Armed Forces and veterans, and workers' compensation boards.

Key Actions for 2002-03

- Support publicly funded, publicly administered Medicare as the fairest and most cost-effective way of delivering health care.
- Continue to work with partners to implement cost-effective approaches to health care.
- Work with the federal government to ensure adequate funding of Medicare.
- Work with regional health authorities to eliminate deficits.
- Review and as necessary revise the funding allocation process for regional health authorities.

Where are we starting from?

According to the Canadian Institute for Health Information, in 1999 the public sector proportion of total health expenditure in Saskatchewan was 76.7%, compared with a national average of 70.8%.

Contact Information

We hope this plan provides useful information about our priorities and plans for the coming year. If you have any questions or comments, or would like additional copies of the plan, we invite you to call our toll-free inquiry line at:

1-800-667-7766

or send us an e-mail through the Saskatchewan Health website:

www.health.gov.sk.ca

Appendix I: Summary of Saskatchewan Health Legislation

The Ambulance Act
Regulates emergency medical technologists/paramedics and funding of ambulance boards.

The Cancer Foundation Act
Sets out funding relationship between Saskatchewan Health and the Saskatchewan Cancer Foundation and its responsibility to provide cancer-related services.

The Change of Name Act, 1995
Administers the registration of legal name changes for residents of Saskatchewan.

The Chiropody Profession Act
Regulates the profession of chiropody/podiatry.

The Chiropractic Act, 1994
Regulates the chiropractic profession.

The Dental Care Act
Governed the department's former dental program and currently allows for the subsidy program for children receiving dental care in northern Saskatchewan.

The Dental Disciplines Act
Omnibus statute regulates the six dental professions of dentistry, dental hygiene, dental therapists, dental assistants, denturists and dental technicians.

The Department of Health Act
Provides the legal authority for the Minister of Health to make expenditures, undertake research, create committees, operate laboratories and conduct other activities for the benefit of the health system.

The Dietitians Act
Regulates dietitians.

The Emergency Medical Aid Act
Provides protection from liability for physicians, nurses and others when they are providing emergency care.

The Health Districts Act
Allows for the establishment and funding of health districts to provide health services.

The Health Facilities Licensing Act
Governs the establishment and regulation of health facilities such as non-hospital surgical clinics.

The Health Information Protection Act (not yet proclaimed)
Protects personal health information in the health system in Saskatchewan.
Establishes a common set of rules that emphasize the protection of privacy, while ensuring that information is available to provide efficient health services.

The Health Services Utilization and Research Commission Act
Allows for the establishment, management and funding of this research body.

The Hearing Aid Act
Governs the provinces hearing aid and audiology program.

The Hearing Aid Sales and Services Act (not yet proclaimed)
Regulates private businesses involved in the selling of hearing aids.

The Home Care Act
Regulates the funding and provision of home care services in the province.

The Hospital Standards Act
Regulates the standards for services delivered in hospitals.

The Housing and Special-Care Homes Act
Regulates the establishment, licensing and funding of special-care homes (long term care facilities) in the province.

The Human Tissue Gift Act
Regulates organ donations in the province.

The Licensed Practical Nurses Act, 2000
Regulates licensed practical nurses in the province.

The Medical and Hospitalization Tax Repeal Act
Ensures premiums cannot be levied under The Saskatchewan Hospitalization Act or The Saskatchewan Medical Care Insurance Act.

Appendix I: Summary of Saskatchewan Health Legislation

The Medical Laboratory Licensing Act, 1994
Governs who can operate a medical laboratory and the services that can be provided by them.

The Medical Laboratory Technologists Act
Regulates the profession of medical laboratory technology.

The Medical Profession Act, 1981
Regulates medical physicians.

The Medical Radiation Technologists Act
Regulates medical radiation technologists.

The Mental Health Services Act
Regulates the provision of mental health services in the province and the protection of mentally disabled people.

The Midwifery Act (not yet proclaimed)
Regulates midwives.

The Mutual Medical and Hospital Benefit Associations Act
Sets out the authority for community clinics to operate in Saskatchewan.

The Naturopathy Act
Regulates naturopathic physicians.

The Occupational Therapists Act, 1997
Regulates occupational therapists.

The Ophthalmic Dispensers Act
Regulates opticians.

The Optometry Act, 1985
Regulates optometrists.

The Osteopathic Practice Act
Regulates osteopathic physicians.

The Personal Care Homes Act
Regulates the establishment, size and standards of services of personal care homes.

The Pharmacy Act, 1996
Regulates pharmacists and pharmacies.

The Physical Therapists Act, 1998
Regulates physical therapists.

The Prescription Drugs Act
Provides authority for the provincial drug plan.

The Psychologists Act, 1997
Regulates psychologists.

The Public Health Act
Some sections of the old Act remain in force in order that governing boards of some facilities continue to operate.

The Public Health Act, 1994
Provides authority for the establishment of public health standards, such as public health inspection of food services.

The Registered Nurses Act, 1988
Regulates registered nurses.

The Registered Psychiatric Nurses Act
Regulates registered psychiatric nurses.

The Saskatchewan Hospitalization Act
Provides for the payment of hospital services and taxes.

The Saskatchewan Medical Care Insurance Act
Sets out authority for the province's medical care insurance program and payments to physicians.

The Senior Citizens' Heritage Program Act
This provides the authority for an obsolete low-income senior citizens program.

The Speech-Language Pathologists and Audiologists Act
Regulates speech-language pathologists and audiologists.

The Tobacco Control Act
The purpose of this Act is to control the sale and use of tobacco and tobacco-related products in an effort to reduce tobacco use, especially among Saskatchewan young people and to protect young people from exposure to second-hand smoke.

The Vital Statistics Act, 1995
Administers the registration of births, deaths, marriages, adoptions and divorces in the Province of Saskatchewan.

The White Cane Act
Sets out the province's responsibilities with respect to services for the visually impaired.

Appendix II: Legislative and Regulatory Amendments

Legislation

A number of pieces of Health legislation were passed in the Legislative Assembly for the Province of Saskatchewan during the Third Session of the 24th Legislature in the spring of 2002.

The Health Quality Council Act

This new legislation will allow for the creation of a Health Quality Council which will be an independent, knowledgeable voice that will provide objective, timely, evidence-based information and advice for achieving the best possible health care within available resources within the province.

The Health Statutes Consequential Amendments Act, 2002

This Act will make consequential amendments to three bilingual statutes as a result of changes being made within *The Regional Health Services Act* and *The Medical Profession Amendment Act, 2002.*

The Medical Profession Amendment Act, 2002

Changes proposed for this Act will provide for the regulation of podiatric surgeons in the province, remove reference to place of training for psychiatrists, clarify and expand incorporation provisions and enhance investigation and discipline procedures.

The Prescription Drugs Amendment Act, 2002

Amendments to this Act are proposed to allow Saskatchewan Health to collect information on all prescriptions in Saskatchewan, regardless of who pays for the prescription and will legislate a duty of pharmacists and others to provide this information.

The Regional Health Services Act

This new Act will address the governance and accountability of the new health regions, will establish standards for the operation of various programs and will repeal *The Health Districts Act.*

The Saskatchewan Health Research Foundation Act

This new legislation will allow for the creation of a research foundation that will design, implement, manage and evaluate funding programs to support a balanced array of health research in the province of Saskatchewan.

The Saskatchewan Medical Care Insurance Amendment Act, 2002

The proposed amendments to this Act will expand the definition of chiropractors, dentists and optometrists to include professional corporations for chiropractic, dental or optometric services and allow for the recovery of monies owing by physicians, chiropractors, dentists and optometrists or their professional corporations when an error is discovered.

The Speech-Language Pathologists and Audiologists Amendment Act, 2002

Amendments to this Act are proposed in order to be consistent with other health profession legislation. The proposed changes are generally housekeeping in nature and will increase the number of public representatives from one to three.

Regulations

A number of regulatory amendments were made in 2001-2002.

The District Health Boards Election Amendment Regulations, 2001

To allow the Saskatchewan Government enough time to analyze and make decisions regarding the recommendations found in The Commission on Medicare Report, district health board elections were deferred one year through amendments to these regulations.

Appendix II: Legislative and Regulatory Amendments

The Health Districts Affiliates Amendment Regulations, 2001

Amendments to these regulations removed Menno Homes of Saskatchewan, Inc. from the list of prescribed affiliates since the facility no longer operated as a special-care home.

The Health Districts Amalgamation Amendment Regulations, 2001

These regulations were amended to prescribe the Melville Ambulance Association Inc. for the purposes of facilitating the amalgamation of this ambulance board with the North Valley District Health Board.

The Hospital Standards Amendment Regulations, 2001

These regulations were amended in 2001 to allow for the repeal of a provision which specified criteria for surgical consent which was contradictory to common law principles.

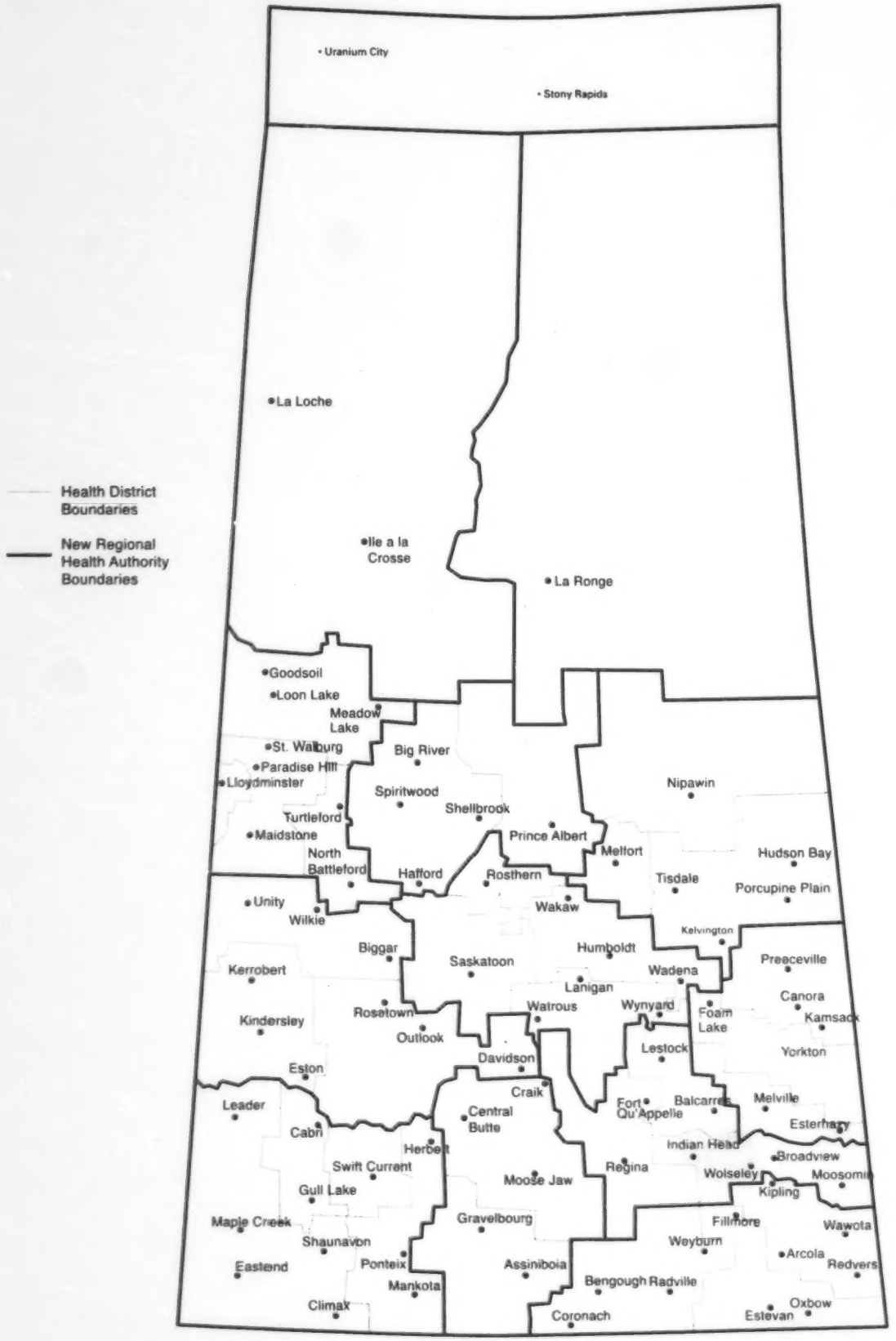
The Saskatchewan Medical Care Insurance Amendment Regulations, 2001; 20011 (No. 2); and 2002

These regulations were amended to address changes negotiated for physician and chiropractic pay schedules.

The Tobacco Control Regulations

These regulations were created to support the proclamation of *The Tobacco Control Act* and provide for requirements for posting signs, distances tobacco vending machines must be located from an entrance, requirements for separate enclosed ventilated smoking rooms within special-care homes and personal care homes over 10 beds and further define the terms "advertise and promote".

Appendix III: Health Districts Map



Appendix IV: Hospital Beds Staffed and in Operation

District	Community	Hospital	Acute Care Beds[2]	Psychiatric Beds	Other Beds (Rehabilitation, LTC, Other)[3,6]	All Beds	Newborn Bassinets
South East	Estevan	St. Joseph's Hospital	53	0	38	91	10
South Central	Weyburn	Weyburn General Hospital	40	0	0	40	4
South Country	Assiniboia	Assiniboia Union Hospital	13	0	4	17	1
	Gravelbourg	St. Joseph's Hospital	9	0	0	9	0
Rolling Hills	Herbert	Herbert-Morse Hospital	13	0	0	13	0
Southwest	Leader	Leader Hospital	23	0	1	24	1
	Maple Creek	Maple Creek Hospital	20	0	1	21	2
	Shaunavon	Shaunavon Hospital & Care Centre	21	0	3	24	2
Moose Mountain	Arcola	Arcola Health Centre	12	0	1	13	1
	Kipling	Kipling Memorial Health Centre	17	0	1	18	1
	Redvers	Redvers Health Centre	13	0	2	15	1
	Wawota*	Wawota Memorial Health Centre	0	0	6	6	0
Pipestone	Broadview	Broadview Union Hospital	18	0	1	19	1
	Indian Head	Indian Head Union Hospital	16	0	2	18	0
	Moosomin	Moosomin Union Hospital	31	0	2	33	1
	Wolseley	Wolseley Memorial Union Hospital	17	0	1	18	1
Regina	Regina	Regina General Hospital (6)	315	50	0	365	61
	Regina	Pasqua Hospital	217	0	9	226	0
Moose Jaw Thunder Creek	Central Butte	Central Butte Union Hospital	5	0	3	8	0
	Moose Jaw	Moose Jaw Union Hospital	85	20	4	109	14
Swift Current	Swift Current	Swift Current Regional Hospital	79	10	0	89	13
North Valley	Esterhazy	St. Anthony's Hospital	22	0	0	22	1
	Melville	St. Peter's Hospital	30	0	5	35	3
Touchwood Qu'Appelle	Balcarres	Balcarres Integrated Care Centre	6	0	4	10	0
	Fort Qu'Appelle	Fort Qu'Appelle Indian Hospital	12	0	6	18	0
	Lestock	St. Joseph's Integrated Care Centre	9	0	7	16	0
East Central	Yorkton	Yorkton Regional Health Centre	80	0	1	81	0
	Foam Lake	Foam Lake Health Centre	4	0	0	4	0
Living Sky	Lanigan	Lanigan Hospital	4	0	6	10	0
	Watrous	Watrous Hospital	4	0	8	12	0
	Wynyard	Wynyard Hospital	8	0	0	8	0
Midwest	Davidson	Davidson & District Health Centre	2	0	6	8	0
	Outlook	Outlook Union Hospital	6	0	13	19	0
	Rosetown	Rosetown and District Health Centre	14	0	7	21	0
Prairie West	Kerrobert	Kerrobert Hospital	6	0	14	20	0
	Kindersley	Kindersley Hospital	16	0	5	21	8
Assiniboine Valley	Canora	Canora Hospital	16	0	12	28	0
	Kamsack	Kamsack Hospital	20	0	18	38	0
	Preeceville	Preeceville Hospital	10	0	11	21	0
Central Plains	Humboldt	St. Elizabeth's Hospital	39	0	3	42	6
	Wadena	Wadena Hospital	14	0	3	17	0
Saskatoon	Saskatoon	Saskatoon City Hospital	170	25	34	229	0
	Saskatoon	St. Paul's Hospital	172	0	12	184	0
	Saskatoon	Royal University Hospital**	263	38	0	321	59
Greenhead	Biggar	Biggar Union Hospital	14	0	1	15	0
	Unity	Unity & District Health Centre	10	0	1	11	1
Pasquia	Hudson Bay	Hudson Bay Health Care Facility	10	0	0	10	1
	Kelvington	Kelvington Hospital	14	0	1	15	0
	Porcupine Plain	Porcupine-Carragana Hospital	10	0	4	14	1
	Tisdale	Tisdale Hospital	24	0	0	24	2
North Central	Melfort	Melfort Hospital	39	0	31	70	4
Gabriel Springs	Rosthern	Rosthern Hospital	30	0	0	30	2
	Wakaw	Wakaw Hospital	20	0	3	23	2
North-East	Nipawin	Nipawin Hospital	38	0	0	38	4
Prince Albert	Prince Albert	Victoria Hospital	102	44	0	146	14
Parkland	Big River	Big River Health Centre	6	0	4	10	0
	Hafford	Hafford Hospital & Special Care Home	0	0	3	3	0
	Shellbrook	Shellbrook & District Hospital	18	0	1	19	0
	Spiritwood	Spiritwood Hospital	8	0	4	12	0
Battlefords	North Battleford	Battlefords Union Hospital	71	22	0	93	9
Twin Rivers	Maidstone	Maidstone Hospital	23	0	2	25	4
	Paradise Hill	Paradise Hill Hospital	13	0	4	17	0
Lloydminster	Lloydminster	Lloydminster Hospital	47	0	2	49	0
Northwest	Loon Lake	Loon Lake Union Hospital & Special Care Home	10	0	3	13	1
	Meadow Lake	Meadow Lake Hospital	21	0	4	25	10
Mamawetan Churchill River	La Ronge	La Ronge Health Centre	22	0	0	22	0
Keewatin Yatthé	Ile a la Crosse	St. Joseph's Hospital	20	0	14	34	2
	La Loche	La Loche Health Centre	10	0	0	14	1
Athabasca	Uranium City***	Uranium City Municipal Hospital	0	0	0	0	0
		TOTAL [7]	2,544	209	340	3,093	249

* Wawota Memorial Health Centre has been operating as a health centre since August 2000.
** Hafford Hospital has been operating as a Health Centre since September 2001.
*** Uranium City Municipal Hospital has been operating as a health centre since August 1999.

(1) Number of beds staffed and in operation on March 31, 2002 was provided by health districts in response to a hospital bed survey conducted by Saskatchewan Health in May 2002. Bed numbers will vary over the course of the year. The survey form was modified slightly this year to improve reporting of sub-acute care beds and to separate out day surgery.

(2) Acute care beds staffed and in operation consist of short-term acute care beds excluding short-term psychiatric beds, newborn bassinets, and neonatal intensive care unit (NICU) beds.

(3) "Other Beds" may include those used for observation, respite,palliative care and convalescent care. On the hospital bed survey they may also be reported as "multipurpose" beds. In the case of combined hospital and licensed special care home facilities, the licensed special care home beds were NOT included in the count of other beds. Although Day Surgery beds were included in this years survey, their numbers were not included in the total acute care beds since they are not staffed and in operation 24 per day

(6) Bassinet count for the Regina General Hospital includes 40 bassinets and 21 neonatal intensive care units (NICU) beds; Royal University Hospital bassinet count includes 34 bassinets and 25 NICU beds.

(7) Total does not include 307 beds in the Wascana Rehabilitation Centre. Wascana Rehabilitation Centre beds include 118 rehabilitation beds, 109 extended care and 80 other long term beds.

Appendix V: Saskatchewan Health Directory of Services

Visit our website at www.health.gov.sk.ca. Some forms and program information may be available online.

1. For a map of Saskatchewan's regional health authorities:

Communications Branch
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6
Telephone: (306) 787-3696

2. For your local regional health authority offices:

Your SaskTel telephone directory will list the district health office nearest you, or consult the Saskatchewan Health website.

3. To report changes to the health registry, or to obtain a health services card, or for more information concerning health registration:

Saskatchewan Health Registration
Saskatchewan Health
1942 Hamilton Street
Regina, SK S4P 3V7

- Regina residents (306) 787-3251 or
- Other residents within the province may call our toll-free number 1-800-667-7551

Or, visit our web site at www.health.gov.sk.ca. Some forms may be available online.

4. For problem gambling prevention and treatment services:

- toll-free Problem Gambling Help Line 1-800-306-6789

5. Supplementary Health Program and Family Health Benefits:

- Regina residents (306) 787-4723 or
- Other residents within the province may call toll-free 1-888-488-6385

6. For information about the Saskatchewan Air Ambulance program:

- Telephone (306) 787-3764

7. For Special Support applications for prescription drug costs:

Either contact your pharmacy, or call:

- Regina residents (306) 787-3317 or
- Other residents within the province may call our toll-free number 1-800-667-7581

8. For additional information about Saskatchewan Aids to Independent Living (SAIL):

- Telephone (306) 787-7121

9. Out-of-province health services:

- Regina residents (306) 787-3437 or
- Other residents within the province may call our toll-free number 1-800-667-7523

Prescription Drug inquiries
- Regina residents (306) 787-3317 or
- Other residents within the province may call our toll-free number 1-800-667-7581

10. To obtain refunds for out-of-province physician and hospital services, and drug costs, forward bills to:

Claims and Benefits
Medical Services Plan
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6 and

Drug Plan and Extended Benefits Branch
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6